DP18-1815 CATEGORY A
Year 5 Evaluation Plan Coversheet

Required Elements of DP18-1815 Category A Evaluation and Performance Measurement Plan

Table 1. Multi-Year Evaluation Approach

Narrative of the Multi-Year Evaluation Approach
Strategies to Evaluate*: Select at least 3 strategies from your work plan that you would like to evaluate over the next 5 years.* A3. Increase engagement of pharmacists in the provision of medication management or DSMES for people with diabetes. A4. Assist Health Care Organizations in implementing systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs for type 2 diabetes prevention. A5. Collaborate with payers and relevant public and private sector organizations within the state to expand the availability of National DPP as a covered benefit. Medicaid, State Employees, Private sector organizations etc.
Evaluation Approach and Context: *Describe the general approach that you will undertake to evaluate the three strategies. Provide information on relevant contextual factors for your program, such as how the program is situated in your state and how it connects to other programs or initiatives. Consider that this document may be viewed separately from your work plan; therefore, provide enough detail for CDC to understand the program and evaluation context.* Georgia's 1815 program will address diabetes management and type 2 diabetes prevention by implementing community clinical linkages and health systems transformation strategies. These strategic approaches will be implemented simultaneously in selected communities across 1815 Category A. The priority populations in these select communities represent adults at high risk for type 2 diabetes who experience racial/ethnic or socioeconomic disparities, individuals 65 years of age and older, men, and people with limited health literacy and/or other disparities that contribute to health status. The set of evaluations proposed will, over time, show how well Georgia's proposed activities for the strategic approaches are working and what changes are needed to improve the program in order to achieve the desired end results. A mixed methods approach, including both quantitative and qualitative methodologies, will be utilized to evaluate the three chosen strategies. The Health Systems Evaluator will collect, code, analyze and interpret data from various data sources described in the Evaluation Design and Data Collection section. Data sources comprise of web-based surveys, program records, interviews, reports from partners such as Centers for Disease Control and Prevention (CDC) on the Diabetes Prevention Recognition Program (DPRP), Georgia Pharmacy Association (GPhA), pEACHealth quarterly reports, National DPP lifestyle change program database retrieved from Georgia Department of Community Health (DCH) (provides data on who has the National DPP lifestyle change program as a covered benefit), and vital statistics data from Georgia Department of Public Health (DPH) Office of Health Indicators and Planning (OHIP). A Community Pharmacy survey will be disseminated annually to collect essential information on the type of pharmacies and the use of Medication Therapy Management (MTM) for diabetes. The DPH-created Health Systems Assessment will be disseminated annually to determine the extent to which health systems in Georgia have polices or systems in place to support high-quality service delivery for their adult primary care patients with respect to screening and management of prediabetes, diabetes, hypertension, and cholesterol. A Partnership Survey will be dispersed to all stakeholders and partners to assess outcomes on efficiencies regarding infrastructure, management, partners, and financial resources since the commencing of this

grant. There is delay in administering the Partnership Survey due to staff changes within DPH and COVID-19 that caused a priority shift with our community partners. The survey will be administered in Q4 of year 4, the results will be shared in year 5.

Delays in dissemination have allowed the evaluation team the opportunity to add additional questions to obtain data related to COVID-19 impact, shifting priorities, and plans for continuing to provide chronic disease programming in the future. Qualtrics, a web-based survey software, will be utilized to survey all intended audiences. The evaluator will summarize and highlight the key findings from Qualtrics surveys completed by health systems and stakeholders. Qualitative responses in the interviews, survey data, and various documents such as program records, will be analyzed by performing descriptive data analysis and conducting thematic analysis. Reports from the pEACHealth project will assist in providing information on progress made with the pharmacy sites regarding the monitoring of A1C measurements and referrals to DSMES programs. Health care organizations that utilize the CATAPULT model to develop policies and processes to implement and refer to established National DPP locations will utilize DPH CATAPULT reporting templates to report outcomes and performance measures on diabetes.

A comprehensive evaluation assessing approach, effectiveness, efficiency, and sustainability of the selected strategies throughout the four years of the grant will help inform the health impact for diabetes outcomes at the end of the cooperative agreement in year 5. The health systems evaluator will ensure monitoring of how activities were implemented under each selected strategy, the collection of measurable outputs, and identify facilitators and barriers to implementing each selected strategy.

In the Spring of 2020, the COVID-19 pandemic resulted in 1815 work having to be delayed and redesigned to accommodate social distancing recommendations and the shift in priorities for Georgia's health systems partners. As the program team continues to work with partners on 1815 efforts, evaluators have re-designed surveys to incorporate questions pertaining to the effects of COVID-19 on 1815 processes to assess the impact of the pandemic on the selected strategies and on partners' commitment to chronic disease prevention programming.

The selection of communities and priority population for adults with high risk for type 2 diabetes were previously identified based on research conducted by Emory School of Public Health to determine trends in diabetes. Emory sought to create a numerical score for Georgia counties that described the population-level health burden of diabetes. The score was created using data from two sources: Behavioral Risk Factor Surveillance System (BRFSS; 2011-2012), and Georgia OASIS Hospital Discharge Files (OASIS; 2015). Evaluation efforts will focus on assessing the strategies implemented and how they contributed to a measurable change in the health, behavior, or environment of the identified communities and priority populations. The retrieval of vital statistics data from DPH OHIP will be utilized to assess some key outcome variables and the program health impact by year 5. Data will be stratified by demographics, such as age, race/ethnicity, and region to assess if activities are impacting priority populations and communities that are disproportionately burdened by diabetes. The evaluator will present the preliminary findings to the Principal Investigator, 1815 Team, and other stakeholders for programmatic interpretation and to develop an action plan based on evaluation findings. Summary briefs and reports will be shared through various channels to share findings and best practices, please see the Communication/Dissemination section for further information.

DPH has an extensive network of partners that will support the achievement of the identified strategies and activities. Georgia also recognizes that collaborating with multiple partners on multiple points in the community and within the health system will improve health outcomes. The team has strengthened training and expertise in the Expanded Chronic Care Model and has bolstered the need for linking community and clinical efforts. By collaboration with hospital systems, public and private organizations, federally qualified health centers (FQHCs), and other clinical partners DPH will be able to create systems transformation and community clinical linkages. Furthermore, partners such as South University School of Pharmacy (South) and Georgia Pharmacy Association (GPhA) will allow for more team-based approaches to care as part of the strategy to address chronic diseases.

DPH is a founding member and participant in the Georgia Clinical Transformation Team (GCT2), a unique interdisciplinary collaboration among groups of various provider organizations within the state. GCT2 was created to collaborate on practice quality improvement and facilitation efforts around cardiac care, obesity, tobacco use and diabetes among Georgia adults through efficient use of healthcare technology and team-based care to improve the health and wellbeing of the population. Beginning in July of 2017, DPH, DCH and the Medicaid Care Management Organizations (CMOs) committed to working together to increase our shared understanding of Diabetes Self-Management Education and Support (DSMES) and the National DPP. To facilitate these efforts, one CMO conducted a pilot project utilizing DSMES at a partner FQHC and lowered the average A1C rates among the 100 participants by more than 1 point. DPH also increased partnership efforts with the Diabetes Training and Technical Assistance Center at Emory University (DTTAC) to increase the number of CDC-recognized lifestyle change programs across the state. Additionally, DPH established memorandums of understanding with Georgia Hospital Association (GHA) and the American Medical Association (AMA) to memorialize two organizations' commitment to work together with health systems across the state, many of which serve the Medicaid and rural population, to increase the number of National DPP sites and to deliver DSMES programs to individuals diagnosed with diabetes.

In order to promote internal collaboration and enhance data collection and management efforts, the Health Systems Evaluator is directly supervised by the Deputy Director for Chronic Disease Evaluation. Additionally, the team working on this grant will collaborate with the Planning and Partnerships team to implement the statewide community health worker initiative. The program recognizes that effective collaboration is vital to providing services and leadership that promote, protect, and improve the health and safety of Georgians. These efforts expand the ability to collect, manage and analyze quality data and to implement evidence-based strategies that apply to the diverse populations in Georgia.

Evaluation Stakeholders and Primary Intended Users of the Evaluation: *Describe individuals or groups who have a stake in the evaluation and who will use the evaluation results. Include a brief description of how you have (or plan to) engaged these evaluation stakeholders.*

Stakeholders of the evaluation include CDC Project Officer; Georgia Department of Public Health (DPH) 1815 Staff; Georgia DPH Chronic Disease Prevention Section, Office of Reporting and Evaluation; Georgia DPH Related Chronic Disease Programs; Georgia DPH, Office of Communications, DPH Office of Health Indicators and Planning (OHIP); Georgia DPH, local Health Departments (i.e., Health Districts), Georgia Pharmacy Association, and Leavitt Partners. Stakeholders/partners will be involved at different levels in the data collection, performance management, and evaluation of the program. DPH Communication will help in developing evaluation results for dissemination to the public/stakeholders. The CDC project officer will use the evaluation results to provide technical assistance and planning of discussions if programmatic changes are recommended. DPH 1815 Staff, Chronic Disease Section, and the Office of Reporting and Evaluation will utilize the evaluation results to inform program planning and quality improvement. DPH local Health Departments may utilize evaluation findings to target services and efforts within respective districts. Georgia Pharmacy Association will assist in data collection and reporting on an annual basis. Leavitt Partners will host interviews with three payers or employers throughout Georgia to expand the availability of National DPP as a covered benefit. The interview results will be shared with DPH. DPH will also collaborate with AMA to evaluate the outcomes of those health care organizations that participated in the AMA learning series to promote the implementation of National DPP. Selected stakeholders and program staff will be engaged in various phases of the evaluation process that include planning, implementation, and the development of measures through communication channels such as email, webinars, and conference calls.

Communication/Dissemination: *Describe your broad plans for communicating/sharing your findings and provide examples of products that you will develop.* The Health Systems Evaluator will collaborate with the Health Systems Team Lead, Diabetes Program Manager, Diabetes Coordinator, DPH Office of Communications and stakeholders to ensure the use of evaluation findings for quality improvement. Evaluation findings will be disseminated through various channels, such as local and national

conferences, meetings, evaluation reports, DPH website, peer-reviewed journals, evaluation briefs, CDC Evaluation Reports, and DPH weekly newsletter. The 1815 team will present the evaluation findings to other 1815 states and local, state, and national level stakeholders through reports and conference calls. Examples of products that will be developed are fact sheets on the latest data and literature on DSMES. In addition, burden reports tailored to various audiences will be developed to share current data on the rates of diabetes in the State of Georgia. Throughout the project duration, the Health Systems Evaluator will submit abstracts to academic and professional conferences about the following topics: the engagement of pharmacist in the provision of MTM or DSMES for people with diabetes; implementing systems to identify people with prediabetes and referring them to CDC -recognized lifestyle change programs for type 2 diabetes prevention.

Use of Evaluation Findings: *Describe how your evaluation findings will be used to ensure continuous quality and programmatic improvement.*

Evaluation findings will be used to ensure continuous quality and programmatic improvement at bi-weekly Health Systems Staff Team Meetings that provide an opportunity for discussion on evaluation updates and the identification of successes, challenges and/or barriers during program implementation. In addition, the Health Systems Evaluator will obtain feedback on ongoing issues related to the evaluation plan. The Health Systems evaluator will collaborate with the DPH 1815 staff and stakeholders to ensure the use of evaluation findings for continuous quality improvement. The evaluator will work collaboratively with the program staff to identify targeted recommendations and action steps and make data-based decisions so that responsible staff can implement programmatic changes to enhance program quality, effectiveness, and efficiency. Collaboration with key program stakeholders offers an opportunity to assess whether priorities and feasibility issues hold for these focused evaluation activities and to refine these evaluation questions throughout the five-year project duration. In addition, data on the impact of COVID-19 on the core areas of evaluation will assist the team in determining the short and long-term effects of the pandemic on the 1815 work.

Year 5. Health Impact*: Describe what you want to be able to say about the contribution of your program to changes in health, behavior, or environment in a defined community, population, organization, or system by the end of the cooperative agreement. Consider what types of evaluation you will need to conduct in years 4, 3, 2, 1 if you want to be able to report health impact for diabetes outcomes at the end of the cooperative agreement in year 5.*

Under this 5-year cooperative agreement, using health system transformation and community clinical linkages approaches, Georgia will improve the health of residents in targeted communities as measured by a composite risk score using the BRFSS and hospital discharge data. Georgia will also reduce geographic gaps in services leading to a reduction in diabetes-related hospitalizations in those same targeted communities.

Evaluation Core Areas	Overarching Core Area Evaluation Questions	Evaluation Design	Data Collection Methods
	Describe what you want to know each year related to the evaluation core area.	*Indicate the type of evaluation you will conduct (e.g. developmental, formative or process, summative and/or outcome).* *What activities will you evaluate? What outcomes will you evaluate from the logic model?*	*Indicate the type of data you will need to answer the evaluation questions (e.g. quantitative, qualitative, both).* *Indicate the potential data collection methods you will use (e.g. program data, surveys, interviews, surveillance data).*

Approach	To what extent has Georgia's implementation approach resulted in achieving the desired outcomes?	Process Evaluation: # pharmacies provided technical assistance and funding support in becoming newly accredited DSMES sites; # pharmacies that receive templated DSMES manuals and accreditation factsheets; Provide funding to implement technology platforms for DSMES data collection and management pharmacies; # of bi-monthly calls for DSMES accredited pharmacies; # of pharmacists that receive MTM/Diabetes training series; Workshop at the Independent Pharmacy annual meeting; # of pharmacy sites that have pEACHealth Project implemented; # of hospitals that receive a 4-part webinar learning series through partnership with AMA; Session conducted on National DPP at the 6th Annual Health Systems Symposium; # of developed new regional communities of practices; Support of one existing community of practice to increase referrals to established National DPP programs; # of interviews conducted with employers/payers throughout Georgia on the expansion of National DPP; # of engagements with employers/payers on the coverage of the National DPP Lifestyle Change Program; Development of evaluation plan for the National DPP "coverage pilot"; Development of survey to Medicaid Manage Care Organizations; Development of landscape survey; Number of COVID related resources	Both quantitative and qualitative data within program records, pEACHealth reports, AMA Learning Series reporting, and interviews hosted by Leavitt Partners

		disseminated to partners; Number of DPP programs offering virtually after COVID	
Effectiveness	a. To what extent has Georgia increased the reach of Category A strategies to prevent and control diabetes? b. To what extent has implementation of Category A strategies led to improved health outcomes among the identified priority population(s)?	a. Outcome Evaluation: # of pharmacies implementing strategies and # of partners; increased number of DSMES programs, increase number of pharmacies and pharmacists providing Medication Therapy Management and lifestyle modification programs; Increase ability to use EHR to identify patients and refer to lifestyle change programs; Increase number of health plans that cover the National DPP lifestyle change program; Decrease in number of DSMES and DPP programs as a direct result of COVID-19 b. Outcome Evaluation: EHR data from priority health districts, hospitalization discharge rates, emergency room rates, and mortality rates	Quantitative data within Program records, Community Pharmacy Survey, Health Assessment Survey, pEACHealth reports, AMA Learning Series reporting, Interviews hosted by Leavitt Partners, and DSMES State Report. Vital Statistics, EHR Data from priority health districts, COVID-19 DPP Impact Surveys, COVID-19 questions in Partnership Surveys and Landscape Analyses, and OHIP data
Efficiency	To what extent has the NOFO affected efficiencies with regard to infrastructure, management, partners, and financial resources?	Process Evaluation: Due to delays from staff changes internally at DPH and among partners, the Partnership Survey will be administered in Q4 of year 4. Partnership Survey is administered to all stakeholders and partners to assess outcomes on efficiencies regarding infrastructure, management, partners, changes to data response rate as a result of COVID-19, and financial resources since the commencing of this grant.	Both quantitative and qualitative data within Program records, Partnership Survey, and AMA Learning Series Key Informant Interviews with HCOs

Sustainability or Data-Driven Decision-Making	To what extent can the strategies implemented be sustained after the NOFO ends?	Process Evaluation: Change in state law related to Collaborative Practice Agreements; Level of coverage for pharmacy delivery of DSMES; Types of funding sources secured to support pharmacy engagement in DSMES programs; Level of adoption by health care providers of new/modified EHR/HIT systems for diagnosis and referral of people with prediabetes; Health care organizational factors that support/ hinder use of EHR/HIT systems for screening, testing and referral of people with prediabetes; Processes put in place to maintain current list of nearby CDC-recognized lifestyle change programs; Change in state law on Medicaid/public/private coverage for National DPP; # of private sector employers and/or private employee health plans that cover National DPP (change from baseline); # of public employers and/or public employee health plans that cover National DPP (change from baseline); # of private insurers that cover National DPP (change from baseline); Number of DPP programs offering virtually after COVID-19; Number of DPP and DSMES programs who have made a permanent change to DPP or DSMES program offering options; Number of programs requiring funds to sustain DPP programs during/following COVID-19; Number of DPP and DSMES programs no longer active following COVID-19	Quantitative data within Program records, Quantitative and Qualitative data from Health Systems Assessment; COVID-19 DPP Impact Surveys; COVID-19 questions in Partnership Surveys and Landscape Analyses

Impact	To what extent have the strategies implemented contributed to a measurable change in health, behavior, or environment in a defined community, population, organization, or system?	Outcome Evaluation: Increased access to and coverage for ADA-recognized/ADCES- accredited DSMES programs for people with diabetes; Increased use of pharmacist patient care processes that promote medication management for people with diabetes; Increased access to and coverage for the National DPP lifestyle change program for people with prediabetes; Increased community clinical links and facilitate referrals and provide support to enroll and retain participants in the National DPP lifestyle change program; Increased participation in ADA recognized/ADCES- accredited DSMES programs by people with diabetes; Increased enrollment and retention in CDC-recognized organizations delivering the National DPP lifestyle change program; Decreased proportion of people with diabetes with an A1C>9; Increased number of people with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved 5-7% weight loss	Quantitative data within Program records, Community Pharmacy Survey, Health Assessment Survey, Partnership Survey, pEACHealth reports, AMA Learning Series reporting, Vital Statistics, EHR Data from priority health districts, BRFSS data, hospital discharge data, DPRP State Evaluation Quarterly Report

Table 2. Program Year 1-5 Evaluation Design and Data Collection

Diabetes Management: Improve care and management of people living with diabetes
(Select the strategy that you will evaluate) ***Note: if you are evaluating more than one strategy in this focus area, please provide the required information for each strategy.***
□ A1. Improve access to and participation in ADA-recognized/ADCES-accredited DSMES programs in underserved areas.
□A.2 Expand or strengthen DSMES coverage policy among public or private insurers or employers, with emphasis on one or more of the following: Medicaid and employers
□ **A3. Increase engagement of pharmacists in the provision of medication management or DSMES for people with diabetes.**

Activity(s): *Provide a brief overview (e.g. 2-3 sentences) of the specific activity(s) in your work plan that you plan to evaluate.*

Under Strategy A.3; DPH will partner with The Georgia Pharmacy Association (GPhA) and OmniSYS (formerly known as STRAND Pharmacy Solution) to increase the number of pharmacies/pharmacists that promote DSMES for patients with diabetes and assist pharmacies in establishing new ADCES-accredited DSMES programs. DPH will educate pharmacists on DSMES, the accreditation process and the benefits of accreditation. Through the partnerships, DPH will bring pharmacists into the patient care process by offering medication therapy management trainings and expanding opportunities to implement Collaborative Practice Agreements (CPAs). The following activities will be evaluated in year 5:

- The partnership with Piedmont Healthcare to complete an analysis of their pilot data to build an ROI for the expansion of the CPA policies.
- Providing technical assistance to approximately 27 DSMES accredited pharmacies and five (5) new pharmacies
- The implementation and expansion of the pEACHealth Project with 14 pharmacy sites in the Coastal, Waycross, Valdosta, Dublin, and Athens health districts.

Evaluation Questions	Indicator(s)	Data Source	Data Collection Method	Data Collection Timing	Data Analysis	Person(s) Responsible	Communication/Dissemination Strategy
What you want to know.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified objective or outcome.*	*Where you will collect the data (i.e., program records, surveys, etc.).*	*How you will collect the data (i.e., abstraction from spreadsheet, database, etc.).*	*When you will collect the data (i.e., start-end date and frequency).*	*What type of analysis you will apply to the data (e.g. descriptive statistics, thematic analysis, etc.)?*	*Who is responsible for collecting the data for this indicator?*	*How you will share findings (i.e., distribution products, channels, and timeline) and how findings will be used by the program.*

		List a source for each indictor.					
Approach: What types of support/resources have DPH 1815-funded activities established or maintained to increase pharmacist delivery of DSMES programs?	# pharmacies provided technical assistance and funding support in becoming newly accredited DSMES sites; # pharmacies that receive templated DSMES manuals and accreditation factsheets; # pharmacies provided funding to implement technology platforms for DSMES data collection and management pharmacies; # of bi-monthly calls for DSMES accredited	Program Records	Retrieved from program records	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Coordinator and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings

	pharmacies; # of pharmacy sites that have pEACHealth Project implemented; Number of pharmacies provided information on virtual DSMES benefit during COVID-19 emergency response						
Effectiveness: How have DPH 1815-funded activities contributed to increasing the availability of pharmacy-based DSMES programs in underserved areas?	# of referrals to pharmacy and non-pharmacy DSMES programs through the implementation of pEACHealth Project; # of people with diabetes with at least one encounter at an ADA-recognized/ADCES-accredited DSMES program,	Program records; GPhA; pEACHealth report; DSMES State Report	Retrieved from program records GPhA reports, pEACHealth reports, and DSMES State Report	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Coordinator and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Community Pharmacy Survey upon completion to share findings

	encountered within pharmacy setting (compared to baseline); # of pharmacy locations offering an ADA-recognized or ADCES-accredited DSMES program (compared to baseline) # of DSMES programs during COVID-19 pandemic						Program stakeholders: Email summary report on Community Pharmacy Survey upon completion to share findings
Efficiency: To what extent have DPH 1815-funded activities affected efficiencies related to infrastructure, management, partnerships, or financial resources to increase pharmacist engagement in the provision of DSMES programs for people with diabetes in	Types of shared partnerships leveraged to promote pharmacy provision of DSMES; Nature/scope of the partnerships- (# funded partnerships and # non-funded partnerships); Types of resources leveraged to support pharmacist engagement in	Partnership Survey and Program Records	Qualtrics web-based survey to partners; Retrieved from program records	Biennial: July 2019-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Coordinator and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report of Partnership Survey upon completion to share findings

underserved areas?	DSMES; survey response rate during COVID-19 pandemic						Program stakeholders: Email summary report on Partnership Survey upon completion to share findings
Sustainability: To what extent will the activities implemented to increase engagement of pharmacist in the provision of DSMES for people with diabetes be sustained after the 1815 NOFO ends?	Change in state law related to Collaborative Practice Agreements; Level of coverage for pharmacy delivery of DSMES; Types of funding sources secured to support pharmacy engagement in DSMES programs; # of DSMES programs that require funds to secure sustainability during/following COVID-19; # of DSMES programs that have implemented a virtual program	Program Records	Retrieved from program records	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Coordinator and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings

	offering option permanently; # of DSMES programs no longer active following COVID-19						
Impact: To what extent has access to pharmacy based DSMES programs contributed to a measurable change in A1C control?	# and % of DSMES participants in pharmacy-based settings with A1C>9 (compared to baseline)	pEACHealth reports	Retrieved from pEACHealth reports	Quarterly and Annually: September 2019-December 2023	Descriptive Statistics	Diabetes Coordinator and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Community Pharmacy Survey upon completion to share findings Program stakeholders: Email summary report on Community Pharmacy Survey upon completion to share findings

Type 2 Diabetes Prevention: Improve access to, participation in, and coverage for the National Diabetes Prevention Program (National DPP) lifestyle change program for people with prediabetes, particularly in underserved areas
(Select the strategy that you will evaluate) ***Note: if you are evaluating more than one strategy in this focus area, please provide the required information for each strategy.***
□ **A4. Assist Health Care Organizations in implementing systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs for type 2 diabetes prevention**
□ **A5. Collaborate with payers and relevant public and private sector organizations within the state to expand the availability of National DPP as a covered benefit. Medicaid, State Employees, Private sector organizations etc.**
□ A6. Implement strategies to increase enrollment in CDC recognized lifestyle change programs.

Activity(s): *Provide a brief overview (e.g. 2-3 sentences) of the specific activity(s) in your work plan that you plan to evaluate.*

Under strategy A.4; DPH will partner with American Medical Association (AMA), the Georgia Hospital Association (GHA), and Georgia Primary Care Association (GPCA) to increase the number of patients served within healthcare organizations that have been referred to a National DPP program by building the capacity of these systems in improving screening, testing, and referrals. The following activities will be evaluated in year 5:

- The continued partnership with GHA, AMA, and GPCA to recruit and fund up to ten (10) hospitals and to implement the National DPP Lifestyle Change program and participate in the 4-part AMA webinar learning series to improve screening, testing, and referring for the National DPP by developing policies and processes for implementation and referrals.
- Provide ongoing tailored technical assistance and pay-for-performance reimbursement to up to fourteen (14) hospitals and five (5) FQHCs focusing on sustainability and expansion of the program.
- The use of DPP landscape analysis to identify current program offerings, contact information, insurance coverage and modality of delivery to be added to an internal DPH DPP registry.

Under strategy A.5; as a result of the Diabetes Prevention State Engagement Meeting (StEM) and in partnership with the National Association for Chronic Disease Directors (NACDD) and Leavitt Partners, DPH will increase the number of employees who have the National DPP as a covered benefit. Leavitt will

assist DPH with identifying high impact employers and NACDD will assist with recruiting employers from high-burden counties to begin implementation of the National DPP. The following activity will be evaluated in year 5:

- Work with the City of Savannah and at least one additional employer to pilot the National DPP and complete an ROI analysis to promote coverage of the National DPP.
- Partnership with Leavitt Partners to obtain an updated Georgia State Profile of providers, payers, and purchasers in Georgia to reflect current landscape of employers and payers offering the National DPP.
- Medicaid Care Management Organizations (CMOs) and Department of Community Health's interest in the coverage of prediabetes screenings, diabetes resources, and/or value-based services offered.

Evaluation Questions	Indicator(s)	Data Source	Data Collection Method	Data Collection Timing	Data Analysis	Person(s) Responsible	Communication/ Dissemination Strategy
What you want to know.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified objective or outcome.*	*Where you will collect the data (i.e., program records, surveys, etc.).* *List a source for each indictor.*	*How you will collect the data (i.e., abstraction from spreadsheet, database, etc.).*	*When you will collect the data (i.e., start-end date and frequency).*	*What type of analysis you will apply to the data (e.g. descriptive statistics, thematic analysis, etc.)?*	*Who is responsible for collecting the data for this indicator?*	*How you will share findings (i.e., distribution products, channels, and timeline) and how findings will be used by the program.*
Approach: What types of support/resources have your 1815-funded established or maintained to increase the	# of hospitals that participate in the 4 to 6-part webinar learning series in partnership with the AMA; # sessions conducted on DPP	Program Records	Retrieved from program records	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program Manager, Education/ Training Specialist, Diabetes	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning

number of patients served within health care organizations with systems to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs?	at the 6th Annual Health Systems Symposium; # of newly developed regional communities of practices to increase referrals to DPP; # of referrals to established DPP programs from existing community practice; # of bi-monthly calls for DSMES accredited pharmacies; # of pharmacists that receive MTM/Diabetes training series					Coordinator, and Health Systems Evaluator	and implementation CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings
Effectiveness: How have DPH 1815-funded activities contributed to strengthening the identification of	# of partnering health care organizations administering the ADA Type 2 Diabetes Risk Test to screen patients for prediabetes; #	Health Systems Assessment; Quarterly data from AMA Learning Series HCO participants;	Qualtrics web-based survey to targeted health systems; Retrieved from quarterly spreadsheet received from	Annually: September 2019-December 2023	Descriptive Statistics and Thematic analysis	Diabetes Prevention Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation

people with prediabetes within health care organizations?	of partnering health care organizations that retrospectively screen for and identify clients with prediabetes using EHRs and patient registries (compared to pre-1815 support; compared to health care organizations not supported by 1815; compare # in underserved areas with other settings); # of partnering health care organizations with prediabetes algorithms in the EHR to assist in identifying and referring patients with prediabetes to CDC-recognized lifestyle change programs (compared to pre-	CATAPULT Reporting	AMA Learning Series HCO participants and CATAPULT Reports				CDC Program Officer and evaluation staff: Email summary report on Health System Assessment upon completion to share findings Program stakeholders: Email summary report on Health System Assessment upon completion to share findings

	1815 support; compared to health care organizations not supported with 1815; compare # in underserved areas with other settings)						
Efficiency: To what extent have DPH 1815-funded activities affected efficiencies related to infrastructure, management, partnerships, or financial resources within partnering health care organizations to increase the referral of people with prediabetes to CDC-recognized lifestyle change?	Types of shared partnerships leveraged to support health care organization diagnosis and referral of people with prediabetes; Types of resources leveraged to support health care organization diagnosis and referral of people with prediabetes; COVID-19 pandemic effect on data response rates	Program Records; AMA Learning Series Key Informant Interviews with HCOs	Retrieved from program records; Key informant structured phone interviews with HCOs who completed AMA Learning Series	Biennial: July 2019-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program Manager, Education/ Training Specialist, Diabetes Coordinator, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings

Sustainability: To what extent will the activities implemented within partnering health care organizations to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs for type 2 diabetes prevention in partnering health care organizations be sustained after the 1815 NOFO ends?	Level of adoption by health care providers of new/modified EHR/HIT systems for diagnosis and referral of people with prediabetes; Health care organizational factors that support/ hinder use of EHR/HIT systems for screening, testing and referral of people with prediabetes; Processes put in place to maintain current list of nearby CDC-recognized lifestyle change programs	Program Records; Health Systems Assessment; CATAPULT Reporting	Retrieved from program records; Qualtrics web-based survey to health systems; Retrieved from CATAPULT Reporting	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Health System Assessment upon completion to share findings Program stakeholders: Email summary report on Health Systems Assessment upon completion to share findings
Impact: To what extent has the implementation of systems	Change in % of National DPP lifestyle change program	Health Systems Assessment; Quarterly data from AMA	Qualtrics web-based survey to health systems; Retrieved from	Annually: September 2019-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program and	DPH 1815 Staff: data collection and preliminary findings will be

within partnering health care organizations to identify people with prediabetes and refer them to CDC-recognized lifestyle change programs contributed to a measurable change in enrollment in the National DPP lifestyle change program?	participants who were referred from an 1815-supported health care organization (compared to % referred from other sources); % of National DPP lifestyle change program participants who were referred from an 1815-supported health care organization who complete the program (compared to % referred from other sources who complete program)	Learning Series HCO participants	quarterly spreadsheet received from AMA Learning Series HCO participants			Health Systems Evaluator	used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Health System Assessment upon completion to share findings Program stakeholders: Email summary report on Health Systems Assessment upon completion to share findings
Approach: How have DPH 1815-funded activities supported collaborating with payers and public and	# of interviews conducted with employers/payers throughout Georgia on the expansion of National DPP; # of	Program Records and Interviews	Retrieved from program records and Interview reports	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning

private sector organizations within your state to expand availability of the National DPP as a covered benefit?	engagements with employers/payers on the coverage of the National DPP Lifestyle Change Program; Development of evaluation plan for the National DPP "coverage pilot"; Development of survey to Medicaid Manage Care Organizations; Development of landscape survey; Number of COVID related resources disseminated to partners; Number of DPP programs offering virtually after COVID						and implementation CDC Program Officer and evaluation staff: Email of annual evaluation report and summary report of interviews will share findings Program stakeholders: Email of annual evaluation report and summary report of interviews will share findings
Effectiveness: How has collaborating with payers and public and private sector organizations	# of local business groups on health engaged (change from baseline); # of private employers and/or private employee	Programs Records and Georgia Department of Community Health (DCH)	Retrieved from program reports and report from the DCH	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning

within Georgia contributed to expanding the coverage of National DPP for Medicaid beneficiaries, state/public employees, and employees of private sector organizations?	health plans that cover National DPP (change from baseline); # of public employers and/or public employee health plans that cover National DPP (change from baseline); # of private insurers that cover National DPP (change from baseline); % of National DPP participants who have coverage (by type of coverage – Medicaid/ private/public/etc.) (change pre/post change in coverage plans)						and implementation CDC Program Officer and evaluation staff: Email of annual evaluation report Program stakeholders: Email of annual evaluation report
Efficiency: To what extent have DPH 1815-funded activities affected	Types of shared partnerships leveraged to support the National DPP as a	Program Records	Retrieved from program records	Biennial: July 2019-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program Manager and	DPH 1815 Staff: data collection and preliminary findings will be used to inform

infrastructure, management, partnerships, or financial resources to expand the availability of the National DPP as a covered benefit for Medicaid beneficiaries, state/public employees, and employees of private sector organizations?	covered benefit; Types of resources leveraged to support the National DPP as a covered benefit					Health Systems Evaluator	program planning and implementation CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings
Sustainability: To what extent will activities implemented to support the expanded availability of the National DPP as a coverage benefit for Medicaid beneficiaries, state/public	Change in state law on Medicaid/public/private coverage for National DPP; # of private sector employers and/or private employee health plans that cover National DPP (change from baseline); # of public employers	Programs Records and Georgia Department of Community Health (DCH)	Retrieved from program reports and report from the DCH	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff:

employees, and employees of private sector organizations be sustained after the NOFO ends?	and/or public employee health plans that cover National DPP (change from baseline); # of private insurers that cover National DPP (change from baseline) # of DPP programs that require funds to secure sustainability during/following COVID-19; # of DPP programs that have implemented a virtual program offering option permanently; # of DPP programs no longer active following COVID-19						Email of annual evaluation report Program stakeholders: Email of annual evaluation report
Impact: To what extent has expanded availability of	# of participants enrolled in CDC-recognized National DPP	CDC DPRP State Evaluation	Retrieved from DPRP State Evaluation	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	Diabetes Prevention Program Manager and	DPH 1815 Staff: data collection and preliminary findings will be

the National DPP lifestyle change program as a covered benefit contributed to a measurable change in increased enrollment in the National DPP by Medicaid beneficiaries, state/public employees, and employees of private sector organizations?	lifestyle change programs; Decreased proportion of people with diabetes with an A1C>9; Increased number of people with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved 5-7% weight loss	Quarterly Report	Quarterly Report			Health Systems Evaluator	used to inform program planning and implementation CDC Program Officer and evaluation staff: Email of annual evaluation report Program stakeholders: Email of annual evaluation report

Table 3. Performance Measurement Plan

Performance Measurement Plan Narrative
How will the quality of performance measure data be assured? The quality of the performance measure data will be assured with creation of standardized data collection tools utilized both internally and externally and the continuous monitoring of data collection by the Health Systems Evaluator. The Health Systems Evaluator will ensure technical assistance is provided to all individuals who collect data that feed into the 1815 Category A performance measures. All released data will have accompanying data dictionary and appropriate documentation that describes the data collection method and limitations for usage of the data. In addition, data will be presented to 1815 staff on a monthly, quarterly, and annual basis to facilitate feedback on evaluation components, program quality improvement, and decision making.
How will performance measurement yield findings to demonstrate progress towards achieving program goals? The performance measurement will yield findings to demonstrate progress towards achieving goals by the collection and analyzation of real-time data on a monthly, quarterly, and annual basis that focus on activities related to community-clinical linkage and health systems change to reduce the burden of diabetes in the state of Georgia through the promotion and use of evidence-based interventions (EBIs).
How will performance measure data be disseminated? The performance measure data will be disseminated through various channels, such as local and national conferences, meetings, evaluation reports, DPH website, peer-reviewed journals, evaluation briefs and DPH weekly newsletter. The 1815 team will present the evaluation findings to other 1815 states and local, state, and national level stakeholders through reports and conference calls. Additionally, fact sheets on the latest data and literature on the latest data and literature on DSMES will be developed and may include performance measure data.
Additional Narrative The baseline of the performance measures is retrieved from 1305 Year 5 performance data. Some baseline measures were unattainable as information was not collected during the 1305 grant. Processes have been put in place to ensure data collection of all measures throughout the 1815 grant cycle. Once Year 1 data was attained, year 1 outcomes were utilized as a baseline throughout the grant years. Proposed targets are comprised of DSMES sites, pharmacies/pharmacists, and health care systems DPH are currently working with and are not reflective of the entire state of Georgia. Targets may be revised to reflect programmatic changes throughout the 5-year grant.

Required Elements of DP18-1815 Category B Evaluation and Performance Measurement Plan

Table 1. Multi-Year Evaluation Approach

Narrative of the Multi-Year Evaluation Approach
Strategies to Evaluate*: Select at least 3 strategies from your work plan that you would like to evaluate over the next 5 years.* B.1. Promote the adoption and use of electronic health records (EHR) and health information technology (HIT) to improve provider outcomes and patient health outcomes related to the identification of individuals with undiagnosed hypertension and management of adults with hypertension. B.5 Develop a statewide infrastructure to promote long-term sustainability for CHWs to promote management of hypertension and high blood cholesterol. B.6. Facilitate use of self-measured blood pressure monitoring (SMBP) with clinical support among adults with hypertension
Evaluation Approach and Context: *Describe the general approach that you will undertake to evaluate the three strategies. Provide information on relevant contextual factors for your program, such as how the program is situated in your state and how it connects to other programs or initiatives. Consider that this document may be viewed separately from your work plan; therefore, provide enough detail for CDC to understand the program and evaluation context.* Georgia's 1815 program will address cardiovascular disease management and prevention by implementing community clinical linkages and health systems transformation strategies. These strategic approaches will be implemented simultaneously in selected communities across 1815 Category B. The priority populations DPH are working with are health care systems within high burden areas that include communities representing adults with undiagnosed or uncontrolled high blood pressure who experience racial/ethnic or socioeconomic disparities, and people with limited health literacy and/or other disparities that contribute to health status. The set of evaluations proposed will, over time, show how well Georgia's proposed activities for the strategic approaches are working and what changes are needed to improve the program in order to achieve the desired end results. A mixed methods approach, including both quantitative and qualitative methodologies, will be utilized to evaluate the three chosen strategies. The Health Systems Evaluator will collect, code, analyze and interpret data from various data sources described in the Evaluation Design and Data Collection section. Data sources comprise of web-based surveys, program records, standardized reports from partners, the retrieval of vital statistics data from Georgia Department of Public Health (DPH) Office of Health Indicators and Planning (OHIP), and the annual data reports from Health Resources Services Administration (HRSA) on Federally Qualified Health Centers (FQHCs). A DPH-designed Health Systems Assessment will be disseminated annually to determine the extent to which health systems in Georgia have policies or systems in place to support high-quality service delivery for their adult primary care patients with respect to screening and management of hypertension and cholesterol. A Community Health Worker (CHW) survey will be developed to identify the CHW workforce in Georgia and assess the engagement of CHWs. In addition, an evaluation of the CHW Stakeholder Forum will be conducted. Findings from the survey will be used to guide the development of a statewide

training, certification program, and CHW network. A Partnership Survey will be dispersed to all stakeholders and partners to assess outcomes on efficiencies regarding infrastructure, management, partners, and financial resources since the commencing of this grant. There is delay in administering the Partnership Survey due to staff changes within DPH and COVID-19 that caused a priority shift with our community partners. The survey will be administered in Q4 of year 4, the results will be shared in year 5. Delays in dissemination have allowed the evaluation team the opportunity to add additional questions to obtain data related to COVID-19 impact, shifting priorities, and plans for continuing to provide chronic disease programming in the future. Qualtrics, a web-based survey software, will be utilized to survey all intended audiences. The evaluator will summarize and highlight the key findings from Qualtrics surveys completed by health systems, CHWs, and stakeholders. Health systems that utilize the CATAPULT framework to develop policies and processes to implement Hypertension Management programs will utilize DPH CATAPULT reporting templates to report outcomes and performance measures on high blood pressure and high blood cholesterol. Qualitative responses in the survey data, key informant interviews, various documents, such as program records, will be analyzed by performing thematic analysis and content analysis. The evaluator will develop open-ended questions for semi-structured interview questions, reports, and surveys to identify the presence of certain words, themes, or concepts within some given qualitative data. The evaluator will develop code categories from collected text and quantify and analyze the presence, meanings and relationships of such certain words, themes, or concepts.

In the Spring of 2020, the COVID-19 pandemic resulted in 1815 work having to be delayed and redesigned to accommodate social distancing recommendations and the shift in priorities for Georgia's health systems partners. As the program team continues to work with partners on 1815 efforts, evaluators have re-designed surveys to incorporate questions pertaining to the effects of COVID-19 on 1815 processes to assess the impact of the pandemic on the selected strategies and on partners' commitment to chronic disease prevention programming. The impact of COVID-19 continues to affect implementation of interventions with DPH and among partners, but focus is shifting back to chronic disease prevention and management. However staffing changes have still affected to shift the focus and keep momentum going.

The selection of communities and priority population for adults with uncontrolled high blood pressure were previously identified based on research conducted by Emory School of Public Health to determine trends in hypertension. Emory sought to create a numerical score for Georgia counties that described the population-level health burden of hypertension. The score was created using data from two sources: Behavioral Risk Factor Surveillance System (BRFSS; 2011-2012), and Georgia OASIS Hospital Discharge Files (OASIS; 2015). Evaluation efforts will focus on assessing the strategies implemented and how they contributed to a measurable change in the health, behavior, or environment of the identified communities and priority populations. The retrieval of vital statistics data from DPH OHIP will be utilized to assess some key outcome variables and the program's health impact by year 5. Data will be stratified by demographics, such as age, race/ethnicity, and region to assess if activities are impacting priority populations and communities that are disproportionately burdened by hypertension. The evaluator will present the preliminary findings to the Principal Investigator, 1815 Team, and other stakeholders for programmatic interpretation and to develop an action plan based on evaluation findings. Summary briefs and reports will be shared through various channels to share findings and best practices, please see the Communication/Dissemination section for further information.

DPH has an extensive network of partners that will support the achievement of the identified strategies and activities. Georgia also recognizes that collaborating with multiple partners among multiple points in the community and in the health system will improve health outcomes. The team has strengthened training and expertise in the Expanded Chronic Care Model and has bolstered the need for linking community and clinical efforts. By collaboration with hospital systems, public and private organizations, federally qualified health centers (FQHCs), and other clinical partners DPH will be able to create systems transformation and community clinical linkages. Furthermore, partners such as South University School of Pharmacy (South) and Georgia Pharmacy Association (GPhA) will allow for more team-based approaches to care as part of the strategy to address chronic diseases.

In order to promote internal collaboration and enhance data collection and management efforts, the Health Systems Evaluator is directly supervised by the Deputy Director for the Office of Health Science. Additionally, the team working on this grant will collaborate with the Office of Planning and Partnerships to implement the statewide community health worker initiative. The program recognizes that effective collaboration is vital to providing services and leadership that promote, protect, and improve the health and safety of Georgians. These efforts expand the ability to collect, manage and analyze quality data and to implement evidence-based strategies that apply to the diverse populations in Georgia.

Evaluation Stakeholders and Primary Intended Users of the Evaluation: *Describe individuals or groups who have a stake in the evaluation and who will use the evaluation results. Include a brief description of how you have (or plan to) engaged these evaluation stakeholders.*

Stakeholders of the evaluation include CDC Project Officers, Georgia Department of Public Health (DPH) 1815 Staff, Georgia DPH Chronic Disease Prevention Section, Reporting and Evaluation Unit; Georgia DPH Related Chronic Disease Programs; Georgia DPH, Office of Health Indicators and Planning (OHIP); Georgia DPH, local Health Departments (i.e., Health Districts), and CATAPULT sites (hospital, clinic, FQHCs). Stakeholders/partners will be involved at different levels in the data collection, performance management, and evaluation of the program. All data collection tools will be created in collaboration with staff on Health Systems Team. Any recommendations to enhance data collection tools will be taken into consideration. Data collection will also be shared with stakeholders to ensure the communication and inclusion of recommendations to enhance data collection methods and tools. The CDC Project Officer will use the evaluation results to provide technical assistance and planning of discussions if programmatic changes are recommended. DPH 1815 Staff, Chronic Disease Section, and the Reporting and Evaluation Unit will utilize the evaluation results to inform program planning and quality improvement. DPH local Health Departments may utilize evaluation findings to target services and efforts within respective districts. Selected stakeholders and program staff will be engaged in various phases of the evaluation process that include planning, implementation, and the development of measures through communication channels such as email, webinars, and conference calls.

Communication/Dissemination: *Describe your broad plans for communicating/sharing your findings and provide examples of products that you will develop.*

The Health Systems Evaluator will collaborate with the Health Systems Team Lead, CVD Program Manager, CVD Coordinator, and CHW Program Manager, DPH Office of Communications and stakeholders to ensure the use of evaluation findings for quality improvement. Evaluation findings will be disseminated

through various channels, such as local and national conferences, meetings, evaluation reports, DPH website, peer-reviewed journals, evaluation briefs, CDC Evaluation Reports. The 1815 team will present the evaluation findings to other 1815 states and local, state, and national level stakeholders through reports and conference calls. Examples of products that will be developed are fact sheets on the latest data and literature on SMBP and Community Health Workers (CHWs). In addition, burden reports tailored to various audiences will be developed to share current data on the incidence rates of hypertension and high blood cholesterol in the State of Georgia.

Use of Evaluation Findings: *Describe how your evaluation findings will be used to ensure continuous quality and programmatic improvement.*

Evaluation findings will be used to ensure continuous quality and programmatic improvement by the conduction of weekly Health Systems Staff Team Meetings that provide opportunities for discussion on evaluation updates and the identification of successes, challenges and/or barriers during program implementation. In addition, the Health Systems Evaluator will obtain feedback on ongoing issues related to the evaluation plan. The Health Systems evaluator will collaborate with the DPH 1815 staff and stakeholders to ensure the use of evaluation findings for continuous quality improvement. The evaluator will work collaboratively with the program staff to identify targeted recommendations and action steps and make data-based decisions so that responsible staff can implement programmatic changes to enhance program quality, effectiveness, and efficiency. Collaboration with key program stakeholders offer opportunity to assess whether priorities and feasibility issues hold for these focused evaluation activities and to refine these evaluation questions throughout the five-year project duration. In addition, data on the impact of COVID-19 on the core areas of evaluation will assist the team in determining the short and long-term effects of the pandemic on the 1815 work.

Year 5. Health Impact*: Describe what you want to be able to say about the contribution of your program to changes in health, behavior, or environment in a defined community, population, organization, or system by the end of the cooperative agreement. Consider what types of evaluation you will need to conduct in years 4, 3, 2, 1 if you want to be able to report health impact for cardiovascular disease outcomes at the end of the cooperative agreement in year 5.*

Under this 5-year cooperative agreement, using health system transformation and community clinical linkages approaches, Georgia will improve the health of residents in targeted communities as measured by a composite risk score using the BRFSS and hospital discharge data. Georgia will also increase control of high blood pressure and cholesterol among Georgian adults with known high blood pressure and high blood cholesterol.

Program Year and Evaluation Core Area	Overarching Core Area Evaluation Questions	Evaluation Design	Data Collection Methods

	Describe what you want to know each year related to the evaluation core area.	*Indicate the type of evaluation you will conduct (e.g. developmental, formative or process, summative and/or outcome).* *What activities will you evaluate? What outcomes will you evaluate from the logic model?*	*Indicate the type of data you will need to answer the evaluation questions (e.g. quantitative, qualitative, both).* *Indicate the potential data collection methods you will use (e.g. program data, surveys, interviews, surveillance data).*
Year 1. Approach	To what extent has Georgia's DPH implementation approach resulted in achieving the desired outcomes?	Process Evaluation: # of webinars and live training conducted in partnership with HI-BRIDGE Solutions; # of healthcare systems recruited for technical assistance on QPP in collaboration with HI-BRIDGE Solutions; # of individuals identified as Georgia Hypertension Control Champions; Collaboration with Diabetes program to organize the Annual Health Systems Symposium; Development of a statewide community health worker program; # of CHWs; Facilitation of the third annual CHW Stakeholder Forum; Partnership with DTTAC and CHW Advisory Board to develop a Hypertension Module to add to the DPP curriculum for Georgia lifestyle coaches; # of institutions offering CHW core competency training; # of CHWs who have received core competency training; # of conferences and webinars provided for healthcare providers on the role of SMBP in successful management of HTN and increased blood pressure control; #	Both quantitative and qualitative data within Program records, Health Assessment Survey, CHW Survey, CHW Stakeholder Forum Evaluation, CATAPULT reporting, COVID-19 questions in Partnership Surveys

		of new health systems in the targeted high-need geographic areas engaged to implement Hypertension Management Programs in their health systems; Utilization of the DPH website to provide updated information on blood pressure control and cardiovascular disease prevention; # of health systems and partners participating in reporting clinical quality measures; # number of health systems encouraging multi-disciplinary team approach to high blood pressure management; # of health systems encouraging self-monitoring of high blood pressure; Number of COVID related resources disseminated to partners; number of programs offered virtually after COVID	
Year 2. Efficiency	To what extent has the NOFO affected efficiencies with regard to infrastructure, management, partners, and financial resources?	Process Evaluation: Partnership Survey will be dispersed within year 2 and year 4 to all stakeholders and partners to assess outcomes on efficiencies regarding infrastructure, management, partners, financial resources, and changes to programming and data response rate as a result of COVID-19 since the commencing of this grant.	Both quantitative and qualitative data within Program records, Partnership Survey, COVID-19 questions in Partnership Surveys, and Healthcare Systems Assessment
Year 3. Effectiveness	a. To what extent has Georgia DPH increased the reach of Category B strategies to	a. Outcome Evaluation: # of health systems, health districts, and pharmacies implementing strategies and # of	Quantitative and qualitative data within Program records, HI-BRIDGE Solutions Reports, Health Assessment Survey, Key

	prevent and control cardiovascular disease? b. To what extent has the implementation of Category B strategies led to improved health outcomes among the identified priority population(s)? c. What factors were associated with the effective implementation of Category B strategies?	partners; # of health system policies; # of newly established statewide CHW training and/or certification program; # and type of referrals that CHWs provide to community-based resources; # continuing education activities via the MCD Public Health online modules, # CHWS enrolled and/or completed continuing education activities; increase ability to use EHR to identify patients with diagnosed and undiagnosed hypertension; increase development of EHR protocols to assist in data retrieval for reporting of quality measures; increase use of Hypertension Management Programs within health systems through CATAPULT; increase of health systems enrolled in the AHA/AMA Target: BP program; Decrease in number of health systems/partners participating as a direct result of COVID-19; Decrease in number of referrals as a direct result of COVID-19 b. Outcome Evaluation: EHR data from priority health districts, hospitalization discharge rates, emergency room rates, and mortality rates, percentage of blood pressure control; number and percentage of adult patients within healthcare systems that have polices or systems to	informant interviews, CATAPULT reporting, Care Coordination Systems (CCS) Hub, Vital Statistics, EHR Data from priority health districts, and COVID-19 questions in Partnership Surveys

		encouraged patient self-measure blood pressure monitoring; percentage of patients ages 18 to 85 with known high blood pressure served by your health care system who have achieved blood pressure control (<140/90) during the measurement year; percentage of patients with high blood pressure who are in adherence to medication regimens (compared to baseline); Percentage of patients with high blood pressure that were referred to an evidence-based lifestyle program; Decrease in number of referrals as a direct result of COVID-19 c. Process and Outcome Evaluation: description of facilitators and barriers to implementation of protocol within health systems; description of the facilitators that improve patient outcomes for hypertension among the identified priority population(s); description of facilitators and barriers among CHWs who completed training and piloted the CCS Hub system; description of the Pathways HUB System and the use standardized, evidence-based and best practice models; description of facilitators and barriers of becoming a CHW Instructor; description of barriers and facilitators to implementing activities	

		within community; description of the facilitators to improve case management by non-physician team members to develop individualized self-management plans and blood pressure self-monitoring for patients with hypertension within each participating health system; description of programmatic barriers encountered as a direct result of COVID-19	
Year 4. Sustainability or Data Driven Decision-Making	To what extent can the strategies implemented be sustained after the NOFO ends?	Process Evaluation: # of trained workers, number of sites that implemented programs and hire trained workers; change in availability of CHW training/certification programs (following 1815 funded support, # of CHW certified, reimbursement of CHWs; Level of adoption by health care providers of new/modified EHR/HIT systems for diagnosis and referral of people with high blood pressure; Health care organizational factors that support/ hinder use of EHR/HIT systems for screening, testing and referral of people with high blood pressure; level adoption of policies by health care systems to encourage SMBP; Number of programs offering virtually after COVID-19; Number of programs who have made a permanent change to program offering	Quantitative data within Program records, CCS Hub, Health Systems Assessment, CATAPULT reporting, CHW Surveys, COVID-19 questions in Partnership Survey and Health Systems Assessment

		options because of COVID-19; Number of programs requiring funds to sustain programs during/following COVID-19; Number of programs no longer active following COVID-19	
Year 5. Impact	To what extent have the strategies implemented contributed to a measurable change in health/clinical outcomes, behavior, or environment in a defined community, population, organization, or system?	Outcome Evaluation: Increased reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of patients with high blood pressure and high blood cholesterol; Increased community clinical links that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol; Increased engagement in self-management among patients with high blood pressure and high blood cholesterol; Increased participation in evidence-based lifestyle interventions among patients with high blood pressure and high blood cholesterol; Increased number of reimbursed CHW; Increased control among adults with known high blood pressure and high blood cholesterol	Quantitative and qualitative data within Program records, Health Assessment Survey, CHW Surveys, Partnership Survey, CCS Hub, YMCA Reports, ARCHI, Vital Statistics, and EHR Data from priority health districts

Table 2. Program Year 5 Evaluation Design and Data Collection

Track and monitor clinical measures shown to improve healthcare quality and identify patients with hypertension **(Select the strategy that you will evaluate)** ***Note: if you are evaluating more than one strategy in this focus area, please provide the required information for each strategy.*** **□B.1 Promote the adoption and use of electronic health records (EHR) and health information technology (HIT) to improve provider outcomes and patient health outcomes related to identification of individuals with undiagnosed hypertension and management of adults with hypertension.** □B.2 Promote the adoption of evidence-based quality measurement at the provider level (e.g., use dashboard measures) to monitor health care disparities and implement activities to eliminate health care disparities
Activity(s): *Provide a brief overview (e.g. 2-3 sentences) of the specific activity(s) in your work plan that you plan to evaluate.* Under Strategy B.1; DPH will continue to collaborate with HI-BRIDGE Solutions (formerly known as GA-HITEC) to continue EHR and HIT support for healthcare systems that developed protocols for retrieving healthcare quality measures data during Year ~~two~~ four. HI-BRIDGE will continue to work with existing partners recruited from previous years to enhance their EHR and HIT capabilities. No new partners will be recruited in year 5. DPH will also work with 2021 Georgia Hypertension Control Champions, which are practices, clinicians, and health systems that have worked with their patients to achieve hypertension control rates of at least 65% to 80%, to conduct additional activities in using electronic health records and health information technology to improve patient outcomes for hypertension through innovations in health information technology and electronic health records, patient communication, and health care team approaches. The following activities will be evaluated in year 5: Quality measures • Impact of enhancements EHR and HIT on the 3 health systems quality measure that conduct a hypertension quality improvement initiative that includes developing protocols to use, and report standardized clinical quality measures for the identification, management and treatment of patients with hypertension through electronic tools such as dashboard. In addition, the development of electronic tools such as dashboards, which will include the use of guideline-based treatment algorithms for hypertension. With technology, systems, and/or dashboards developed or upgraded using 1815 funding, the ongoing use of these electronic tools will provide a sustainable mechanism for improved provider outcomes related to identification and management of adults with hypertension. • The Georgia Hypertension Control Champions and the engagement of the practices and systems to focus on conducting additional innovations in using evidenced-based digital interventions to improve patient outcomes for hypertension utilizing the guidance from the Community Preventive Service Task Force Guide. With technology, systems, and/or dashboards developed or upgraded using 1815 funding, the ongoing use of these

Figure 1. Georgia's Innovative Strategies to Advance Health Equity and Access through Diabetes/Hypertension care Logic Model

electronic tools will provide a sustainable mechanism for improved provider outcomes related to identification and management of adults with hypertension.							
Evaluation Questions	**Indicator(s)**	**Data Source**	**Data Collection Method**	**Data Collection Timing**	**Data Analysis**	**Person(s) Responsible**	**Communication/Dissemination Strategy**
What you want to know.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified objective or outcome.*	*Where you will collect the data (i.e., program records, surveys, etc.).* *List a source for each indicator.*	*How you will collect the data (i.e., abstraction from spreadsheet, database, etc.).*	*When you will collect the data (i.e., start-end date and frequency).*	*What type of analysis you will apply to the data (e.g. descriptive statistics, thematic analysis, etc.)?*	*Who is responsible for collecting the data for this indicator?*	*How you will share findings (i.e., distribution products, channels, and timeline) and how findings will be used by the program.*
Approach: What type of support/ resources have 1815-funded activities established or maintained to increase the identification of	# of webinars and live training conducted in partnership with HI-BRIDGE Solutions; # of healthcare systems recruited for technical assistance on QPP in collaboration with	Program Records and HI-BRIDGE Solutions reports	Retrieved from program records and HI-BRIDGE Solutions quarterly reports	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email of annual

Figure 1. Georgia's Innovative Strategies to Advance Health Equity and Access through Diabetes/Hypertension care Logic Model

individuals with undiagnosed hypertension and management of adults with hypertension through the adoption and use of EHR and HIT?	HI-BRIDGE Solutions; # of individuals identified as Georgia Hypertension Control Champions; Collaboration with Diabetes program to organize the Annual Health Systems Symposium; # of partners provided resources/TA to continue operating during COVID-19						evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings
Approach: To what extent has the implementation of the strategies increased the number of health systems and partners participating in reporting clinical quality measures?	Number and percentage of patients within health care systems with systems to report standardized clinical quality measures for the identification, management and treatment of patients with hypertension (compared to baseline); # of health	Program Records and HI-BRIDGE Solutions reports	Retrieved from program records and HI-BRIDGE Solutions quarterly reports	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings

Figure 1. Georgia's Innovative Strategies to Advance Health Equity and Access through Diabetes/Hypertension care Logic Model

	systems/partners delayed in reporting or unable to report due to COVID-19						Program stakeholders: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings
Approach: What innovations in health information technology and electronic health records, patient communication, and health care team approaches that identified Hypertension Control Champions conducted to achieve	Description of the facilitators and barriers in achieving hypertension control rates, description of policies and protocols; description of barriers in programming due to COVID-19	Key informant interviews with identified Hypertension Control Champions	Retrieved from Interviews with Hypertension Control Champions	August 2019	Thematic Analysis	CVD Program Manager, CVD Coordinator, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on interviews upon completion to share findings Program stakeholders: Email summary report on interviews upon completion to share findings

Figure 1. Georgia's Innovative Strategies to Advance Health Equity and Access through Diabetes/Hypertension care Logic Model

hypertension control rates?							
Approach: To what extent has the implementation of the strategies increased the number of developed protocols among health systems for retrieving healthcare quality measures data to identify patients with undiagnosed hypertension and diagnosed hypertension?	Number of developed protocols among health care systems for retrieving healthcare quality measures data to identify patients with undiagnosed hypertension and diagnosed hypertension (compared to baseline); # of health systems delayed in developing protocols due to COVID-19	Program Records and HI-BRIDGE Solutions reports	Retrieved from program records and HI-BRIDGE Solutions quarterly reports	Annually: September 2018-December 2023	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings Program stakeholders: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings
Approach: To what extent has the	Number of health care systems reporting QPP	Program Records and HI-BRIDGE	Retrieved from program records and HI-	Annually: September	Descriptive Statistics and	CVD Program Manager, Health Systems Lead,	DPH 1815 Staff: data collection and preliminary findings

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implementation of the strategies improved the reporting of QPP measures related to hypertension and high blood pressure?	measures related to hypertension and high blood pressure (compared to baseline); # of health systems delayed in reporting or unable to report due to COVID-19	Solutions reports	BRIDGE Solutions quarterly reports	2018-December 2023	Thematic Analysis	and Health Systems Evaluator	will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings Program stakeholders: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings
Efficiency: To what extent have 1815 funded activities affected efficiencies related to infrastructure,	Types of shared partnerships leveraged to support healthcare systems use of HIT and EHR for quality improvement of providers outcomes and health	Health Systems Assessment and Partnership Survey	Retrieved from Qualtrics web-based survey	Annually: April-June 2020	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff:

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management, partnership, or financial resources within partnering health care systems to improve the leveraging of HIT and EHR for quality improvement of providers outcomes and health outcomes for patients with hypertension?	outcomes for patients with hypertension; Types of resources leveraged to support healthcare systems use of HIT and EHR for quality improvement of providers outcomes and health outcomes for patients with hypertension; Description of facilitators and barriers of implementation of activities; survey response rate during COVID-19						Email summary report on Partnership Survey upon completion to share findings Program stakeholders: Email summary report on Partnership Survey upon completion to share findings
Effectiveness: How has the implementation of the hypertension quality improvement initiatives	# of developed protocols to use and report standardized clinical quality measures for the identification, management, and treatment of	Program Records and HI-BRIDGE Solutions reports	Retrieved from program records and HI-BRIDGE Solutions quarterly reports	Annual: July 2020-June 2021	Descriptive Statistics and Thematic Analysis	CVD Program Manager, CVD Coordinator, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation

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contributed to the improvement of the identification of individuals with undiagnosed hypertension and the management of adults with hypertension among the five health systems?	patients with hypertension; the establishment of electronic tools such as dashboards which will include the use of guideline-based treatment algorithms for hypertension; promotion of clinical decision supports embedded in the EHR for the identification and treatment of disparities in hypertension care among health systems; delays in number of protocols or electronic tools developed as a result of COVID-19						CDC Program Officer and evaluation staff: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings Program stakeholders: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings
Effectiveness: What factors were associated with the implementation	# of new or enhanced protocols established during reporting period; description of	Program Records and HI-BRIDGE	Retrieved from program records and HI-BRIDGE Solutions	Annual: July 2020-June 2021	Descriptive Statistics and Thematic Analysis	CVD Program Manager, CVD Coordinator, and Health	DPH 1815 Staff: data collection and preliminary findings will be used to inform

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of protocols within health systems to use and report standardized clinical quality measures for the identification, management and treatment of patients with hypertension through electronic tools such as dashboards?	facilitators and barriers to implementation of protocol within health systems; delays in protocol development or implementation due to COVID-19	Solutions reports	quarterly reports			Systems Evaluator	program planning and implementation CDC Program Officer and evaluation staff: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings Program stakeholders: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings
Effectiveness: To what extent has the implementation of the hypertension quality improvement initiatives led to improved	Increase in the percentage of blood pressure control among priority populations compared from baseline. Assess stratification of race, age, sex.; delays in data collection and	HI-BRIDGE Solution Reports	HI-BRIDGE Solutions quarterly reports	Annual: July 2020-June 2021	Descriptive Statistics	CVD Program Manager, CVD Coordinator, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report

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health outcomes among the identified priority population(s) within the five health systems?	reporting due to COVID-19						on HI-BRIDGE Solutions completed assessments upon completion to share findings Program stakeholders: Email summary report on HI-BRIDGE Solutions completed assessments upon completion to share findings
Effectiveness: To what extent has the use of EHR and HIT improve patient outcomes for hypertension among the identified priority population(s) within the three identified Hypertension Control	Description of the facilitators that improve patient outcomes for hypertension among the identified priority population(s); percentage of hypertension control rate compared to previous years; delays in data collection and	Key informant interviews with identified Hypertensio n Control Champions	Retrieved from Interviews with Hypertension Control Champions	Annual: July 2020-June 2021	Thematic Analysis	CVD Program Manager, CVD Coordinator, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on interviews upon completion to share findings Program stakeholders: Email

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Champion practices?	reporting due to COVID-19						summary report on interviews upon completion to share findings
Sustainability/ Data Driven Decision Making: To what extent will the implemented protocols to use and report standardized clinical quality measures for the identification, management and treatment of patients with hypertension through electronic tools such as dashboards be sustained within the	Level of adoption by health care providers of new/modified EHR/HIT systems for diagnosis and referral of people with high blood pressure; Health care organizational factors that support/ hinder use of EHR/HIT systems for screening, testing and referral of people with high blood pressure; Number of programs offering virtually after COVID-19; Number of programs who have made a permanent change to program offering options because of	Program Records and HI-BRIDGE Solutions reports; Health Systems Assessment and Partnership Survey	Retrieved from program records, HI-BRIDGE Solutions quarterly reports, and Qualtrics web-based survey	Annually: July 2021-June 2023	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Partnership Survey upon completion to share findings Program stakeholders: Email summary report on Partnership Survey upon completion to share findings

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health systems after the NOFO ends?	COVID-19; Number of programs requiring funds to sustain programs during/following COVID-19; Number of programs no longer active following COVID-19						
Sustainability/ Data Driven Decision Making: To what extent will the use of EHR and HIT to improve patient outcomes for hypertension be sustained within the Hypertension Control Champions after the NOFO ends?	Level of adoption by health care providers of new/modified EHR/HIT systems for diagnosis and referral of people with high blood pressure; Health care organizational factors that support/ hinder use of EHR/HIT systems for screening, testing and referral of people with high blood pressure; Number of programs offering virtually after COVID-19;	Program Records and HI-BRIDGE Solutions reports; Health Systems Assessment and Partnership Survey	Retrieved from program records, HI-BRIDGE Solutions quarterly reports, and Qualtrics web-based survey	Annually: July 2021-June 2023	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Partnership Survey upon completion to share findings Program stakeholders: Email summary report on Partnership Survey upon completion to share findings

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	Number of programs who have made a permanent change to program offering options because of COVID-19; Number of programs requiring funds to sustain programs during/following COVID-19; Number of programs no longer active following COVID-19						
Impact To what extent have the strategies implemented contributed to a measurable change in health/clinical outcomes, behavior, or environment in a defined	Proportion of systems that made enhancements to EHR /HIT for tracking quality measures for hypertension management	Program Records and HI-BRIDGE Solutions reports; Health Systems Assessment	Retrieved from program records, HI-BRIDGE Solutions quarterly reports, and Qualtrics web-based survey	July 2022-June 2023	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	Results of this project will be used for further program planning and implementation on interventions in Georgia. Program results will be disseminated through reports and presentations at local,

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community, population, organization, or system?							state, regional, and national meetings and conferences when possible. Reports will also be shared with all stakeholders through the DPH websites.

Link Community Resources and Clinical Services that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol
(Select the strategy that you will evaluate) ***Note: if you are evaluating more than one strategy in this focus area, please provide the required information for each strategy.***
□**B.5 Develop a statewide infrastructure to promote sustainability for CHWs to promote management of hypertension and high blood cholesterol**
□**B.6 Facilitate use of self-measured blood pressure monitoring (SMBP) with clinical support among adults with hypertension**
□B.7 Implement systems to facilitate systematic referral of adults with hypertension and/or high blood cholesterol to community programs/resources

Activity(s): *Provide a brief overview (e.g. 2-3 sentences) of the specific activity(s) in your work plan that you plan to evaluate.*

Under Strategy B.5; DPH will continue to partner with Care Coordination System (CCS) to monitor and manage the Pathways HUB System for Georgia CHWs who completed the CCS Curriculum Training in Year 2. DPH will continue to engage the CHW Advisory Board and implementation of the CHW statewide strategic efforts. A bilingual CHW curriculum will be developed in collaboration with the University of Georgia. DPH will also continue providing continuing education activities for professional development for CHWs to maintain future certification requirements. The following activities will be evaluated for year 5:

- The success of GA CHW Network to establish a tiered workforce model. DPH completed the development of the Bilingual CHW training curriculum.

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- Number of CHWs completing modules and number of modules completed. DPH will continue to provide continuing education activities via the MCD Public Health online modules (in English and Spanish) for professional development for CHWs to maintain future certification requirements.
- DPH completed the establishment and implementation of the CHW Network. In year 5, DPH will continue with resource sharing and certification process and evaluate the impact of the network of CHW roles and work in communities.
- Training of supervisors/employers on the CHW Toolkit on Hypertension focus.
- Training of CHWs on the Georgia Healthy Heart Ambassador Blood Pressure Self-Monitoring Program (GAHHA-BPSM) training curriculum.

Under Strategy B.6; Continue to partner with Georgia Primary Care Association (GPCA), the American College of Physicians – Georgia Chapter (ACP), and DPH Maternal and Child Health Section to engage health systems to implement Hypertension Management programs utilizing the CATAPULT framework. The following activities will be evaluated for year 5:

- The impact of utilizing non-physician team members to develop individualized self-management plans and blood pressure self-monitoring for patients with hypertension.
- The partnership with Georgia Primary Care Association (GPCA) and American College of Physicians – Georgia Chapter (ACP) to engage health systems to implement sustainable Hypertension Management programs utilizing the CATAPULT framework.
- The CATAPULT Collaborative, a networking group that engages all partnering health systems to share best practices, tools, and innovations related to SMBP, team-based care, and cholesterol management; a group requiring few resources and highly sustainable beyond 1815 funding.

Evaluation Questions	**Indicator(s)**	**Data Source**	**Data Collection Method**	**Data Collection Timing**	**Data Analysis**	**Person(s) Responsible**	**Communication /Dissemination Strategy**
What you want to know.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified*	*Where you will collect the data (i.e., program records, surveys, etc.).*	*How you will collect the data (i.e., abstraction from spreadsheet, database, etc.).*	*When you will collect the data (i.e., start-end date and frequency).*	*What type of analysis you will apply to the data (e.g. descriptive statistics,*	*Who is responsible for collecting the data for this indicator?*	*How you will share findings (i.e., distribution products, channels, and timeline) and how findings will*

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	objective or outcome.	*List a source for each indicator.*			*thematic analysis, etc.)?*		*be used by the program.*
Approach: To what extent has implementation of the strategies facilitated the identification of CHWs within the state of GA?	Number of CHWs identified in the state of GA, number of CHWs that participate in CHW advisory board, number of CHW and CHW supporters convened to formalize state-level efforts to advance CHW work; number of CHWs continuing virtual involvement in efforts after COVID-19	Program Records, CWH Survey, CHW Stakeholder Forum Evaluation	Retrieved from program records, Qualtrics web-based survey to CHWs	Annually: September 2018 – December 2023	Descriptive Statistics and Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on CHW Survey and CHW Stakeholder Forum Evaluation upon completion to share findings Program stakeholders: Email summary report on CHW Survey and CHW

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							Stakeholder Forum Evaluation upon completion to share findings
Approach: What type of partnerships have DPH 1815 funded activities supported to engage delivery vehicles and mechanisms in offering CHW core competency training?	Number/type of partnerships established to engage training delivery vehicles and mechanisms; Nature/scope of partnerships (# funded partnerships and # non-funded partnerships); type of stakeholders engaged; number/type of resources provided to support virtual delivery due to COVID-19	Program Records	Retrieved from program records	Annually: September 2018 – December 2023	Descriptive Statistics and Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation. CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings

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Efficiency: To what extent have 1815-funded activities affected infrastructure, management, partnerships, or financial resources to establish or expand training opportunities for CHWs in GA?	Type of partnerships established to expand training opportunities for CHWs (# of funded partnerships; # of non-funded partnerships); types of resources leveraged to expand training opportunities for CHWs; COVID-19 effect on data response rates	Program Records	Retrieved from program records	Annually: September 2019– December 2023	Descriptive Statistics and Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation. CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings
Efficiency: To what extent has the CHW Instructor Training affected infrastructure,	Descriptions of facilitators and barriers encountered since participating in instructor	Partnership Survey	Retrieved from Qualtrics web-based survey	Annually: April-June 2020	Descriptive Statistics and Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program

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management, partnerships, or financial resources of the 3 CHWs within their organizations that serve as trainers for the CCS Curriculum?	training program; Type of partnerships established to facilitate training opportunities (# of funded partnerships; # of non-funded partnerships); types of resources leveraged to ensure sustainability of trainings; description of COVID-19 barriers affecting training/programming						planning and implementation CDC Program Officer and evaluation staff: Email summary report on Partnership Survey upon completion to share findings Program stakeholders: Email summary report on Partnership Survey upon completion to share findings
Effectiveness: How has the CHW Instructor Training and the use of the CCS Hub system to track referrals increased the	# and type of referrals that CHWs provide to community-based resources; description of the Pathways HUB System and	Program Records and survey	Retrieved from program records and follow up survey administered to CHWs for this activity	July 2020-June 2021	Descriptive Statistics and Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program

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reach of CHWs to prevent and manage cardiovascular disease within their communities?	the use standardized, evidence-based and best practice models; description of facilitators and barriers among CHWs who completed training and piloted the CCS Hub system; description of data reporting/tracking barriers encountered due to COVID-19						planning and implementation. CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings
Effectiveness: To what extent has the CHW Instructor Training for the 3 CHWs led to effective implementation of activities such as improving	Description of facilitators and barriers of becoming a CHW Instructor; Description of barriers and facilitators to implementing activities within	Key informant interviews	Retrieved from key informant interviews with the CHWs	July 2020-June 2021	Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation.

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cardiovascular health within their communities?	community; description of activity implementation barriers due to COVID-19						CDC Program Officer and evaluation staff: Email of final key informant interview report Program stakeholders: Email of final key informant interview report
Effectiveness: How have the 1815-funded activities contributed to developing statewide infrastructure to promote long-term sustainability in offering core competency training to CHWs?	# of newly established statewide CHW training programs; # continuing education activities via the MCD Public Health online modules, # CHWs enrolled and/or completed continuing education activities; # of CHWs delayed in	Program Records and administered follow up survey to CHWs who completed CEU	Retrieved from program records and CEU follow up survey	July 2020-June 2021	Descriptive Statistics and Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation. CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings

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	completing continuing education activities due to COVID-19						Program stakeholders: Email of annual evaluation report will share findings
Sustainability/ Data Driven Decision Making: To what extent has the collaboration with the University of Georgia to develop a Bilingual CHW training curriculum increased the statewide infrastructure for CHWs to promote management of hypertension and high blood	Receipt of one each sets of ready-to-use Spanish and English curriculum from UGA; # of CHWs finding curriculum beneficial; # CHWs finding curriculum relevant; # CHWs who will continue the work post-curriculum training	Program Records and survey	Retrieved from program records and follow up survey administered to CHWs for this activity	July 2021-June 2023	Descriptive Statistics and Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation. CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings

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cholesterol in Georgia beyond grant funding.							
Sustainability/ Data Driven Decision Making: To what extent will continuing education activities for professional development for CHWs to maintain future certification requirements be sustained after the NOFO ends?	# of newly established statewide CHW training programs; # continuing education activities via the MCD Public Health online modules, # CHWs enrolled and/or completed continuing education activities; # of CHWs delayed in completing continuing education activities due to COVID-19	Program Records and administered follow up survey to CHWs who completed CEU	Retrieved from program records and CEU follow up survey	July 2021-June 2023	Descriptive Statistics and Thematic Analysis	CHW Initiative Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation. CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings
Approach: What types of support/	# of conference and webinars provided for	Program Records	Retrieved from program records	Annually: September	Descriptive Statistics and	CVD Program Manager, Health Systems Lead,	DPH 1815 Staff: data collection and preliminary

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resources have 1815-funded activities established or maintained to facilitate use of SMBP with clinical support among adults with hypertension?	health care providers on the role of SMBP in successful management of HTN and increase blood pressure control; # of new health systems in the targeted hi-need geographic areas engaged to implement Hypertension Management Programs in their health systems; utilization of the DPH website to provide updated information on blood pressure control and cardiovascular disease prevention; # of health systems delayed in implementing			2018-December 2023	Thematic Analysis	and Health Systems Evaluator	findings will be used to inform program planning and implementation. CDC Program Officer and evaluation staff: Email of annual evaluation report will share findings Program stakeholders: Email of annual evaluation report will share findings

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	Hypertension Management Programs due to COVID-19						
Approach: To what extent has implementation of the strategies increase the number of health systems encouraging self-monitoring of high blood pressure?	Number and percentage of patients within health care systems that have policies or systems to encourage SMBP with clinical support for patients with hypertension (compared to baseline); COVID-19 effect on data response rates	Health Systems Assessment; CATAPULT Reporting	Qualtrics web-based survey to targeted health systems; Retrieved from CATAPULT Reporting	Annually: September 2018-December 2023	Descriptive Statistics and Thematic analysis	CVD Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Health System Assessment upon completion to share findings Program stakeholders: Email summary report on Health System Assessment

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							upon completion to share findings
Efficiency: To what extent have 1815-funded activities affected the infrastructure, management, partnerships, or financial resources within partnering health care systems that utilize CATAPULT framework to implement Hypertension Management programs?	Types of partnerships leveraged to support health care systems to implement Hypertension Management programs; Types of resources leveraged to support health care systems to implement Hypertension Management programs; # and types of resources provided to partners to continue programming during COVID-19	CATAPULT Report and Partnership Survey	Retrieved from Qualtrics web-based survey	Annually: April-June 2020	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Partnership Survey upon completion to share findings Program stakeholders: Email summary report on Partnership Survey upon completion to share findings

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Effectiveness: How has the CATAPULT framework strengthened interventions that focus on SMBP among participating health systems?	Description of the facilitators to improve case management by non-physician team members to develop individualized self-management plans and blood pressure self-monitoring for patients with hypertension within each participating health system	CATAPULT Reporting	Retrieved from CATAPULT Reporting	Annually: July 2020-June 2021	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on CATAPULT upon completion to share findings Program stakeholders: Email summary report on CATAPULT upon completion to share findings
Effectiveness: To what extent has the implementation of the quality	Number and percentage of adult patients within healthcare systems that	CATAPULT Reporting	Retrieved from CATAPULT Reporting	Annually: July 2020-June 2021	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health	DPH 1815 Staff: data collection and preliminary findings will be used to inform

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improvement initiatives through CATAPULT improve cardiovascular outcomes within participating health systems?	have polices or systems to encouraged patient self-measure blood pressure monitoring (compared to baseline); Percentage of patients ages 18 to 85 with known high blood pressure served by your health care system who have achieved blood pressure control (<140/90) during the measurement year (compared to baseline); Percentage of patients with high blood pressure who are in adherence to					Systems Evaluator	program planning and implementation CDC Program Officer and evaluation staff: Email summary report on CATAPULT upon completion to share findings Program stakeholders: Email summary report on CATAPULT upon completion to share findings

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	medication regimens (compared to baseline); Percentage of patients with high blood pressure that were referred to an evidence-based lifestyle program (compared to baseline); Decrease in number of referrals as a direct result of COVID-19						
Sustainability/ Data Driven Decision Making: To what extent will the case management by non-physician team members	level of adoption of policies by health care systems to encourage SMBP; Number and percentage of non-physician team members within health	Health Systems Assessment; CATAPULT Reporting	Qualtrics web-based survey to targeted health systems; Retrieved from CATAPULT Reporting	Annually: September 2018-December 2023	Descriptive Statistics and Thematic analysis	CVD Program Manager and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation

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to develop individualized self-management plans and blood pressure self-monitoring for patients with hypertension be sustained after the NOFO ends?	care systems that have policies or systems to encourage SMBP with clinical support for patients with hypertension						CDC Program Officer and evaluation staff: Email summary report on Health System Assessment upon completion to share findings Program stakeholders: Email summary report on Health System Assessment upon completion to share findings
Sustainability/ Data Driven Decision Making: To what extent will the use of the CATAPULT framework by health care systems to implement	# of health systems with policies in place to implement Hypertension Management programs utilizing the CATAPULT framework	CATAPULT Report and Partnership Survey	Retrieved from Qualtrics web-based survey	Annually: April-June 2020	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	DPH 1815 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff:

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Hypertension Management programs be sustained after the NOFO ends?							Email summary report on Partnership Survey upon completion to share findings Program stakeholders: Email summary report on Partnership Survey upon completion to share findings

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Impact: To what extent have the strategies implemented contributed to a measurable change in health/clinical outcomes, behavior, or environment in a defined community, population, organization, or system?	Level of involvement of non-physicians on care teams; Number of patients successfully developed community clinical links; Number of patients managing their high blood pressure and high blood cholesterol; Number of CHW engaged in the communities. Trainings of CHWs, Topic of trainings.	Program Records and HI-BRIDGE Solutions reports; Health Systems Assessment	Retrieved from program records, HI-BRIDGE Solutions quarterly reports, and Qualtrics web-based survey	July 2022-June 2023	Descriptive Statistics and Thematic Analysis	CVD Program Manager, Health Systems Lead, and Health Systems Evaluator	Results of this project will be used for further program planning and implementation on interventions in Georgia. Program results will be disseminated through reports and presentations at local, state, regional, and national meetings and conferences when possible. Reports will also be shared with all stakeholders through the DPH websites.

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Table 3. Performance Measurement Plan

		Performance Measurement Plan Narrative
		How will the quality of performance measure data be assured? The quality of the performance measure data will be assured with the creation of standardized data collection tools utilized both internally and externally and the continuous monitoring of data collection by the Health Systems Evaluator. The Health Systems Evaluator will ensure technical assistance is provided to all individuals who collect data that feed into the 1815 Category B performance measures. In addition, data will be presented to 1815 staff on a monthly, quarterly, and annual basis to facilitate feedback on evaluation components, program quality improvement, and decision making.
		How will performance measurement yield findings to demonstrate progress towards achieving program goals? The performance measurement will yield findings to demonstrate progress towards achieving goals by the collection and analyzation of real-time data on a monthly, quarterly, and annual basis that focus on activities related to community-clinical linkage and health systems change to reduce the burden of hypertension in the state of Georgia through the promotion and use of evidence-based interventions (EBIs).
		How will performance measure data be disseminated? The performance measure data will be disseminated through various channels, such as local and national conferences, meetings, evaluation reports, DPH website, peer-reviewed journals, evaluation briefs and DPH weekly newsletter. The 1815 team will present the evaluation findings to other 1815 states and local, state, and national level stakeholders through

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		reports and conference calls. Additionally, fact sheets on the latest data and literature on SMBP and CHWs will be developed and may include performance measure data.
		Additional Narrative The baseline of the performance measures is retrieved from 1305 Year 5 performance data or Year 1 data collection. Some baseline measures were unattainable as information was not collected during the 1305 grant. In addition, currently selected health systems for 1815 strategies have not completed the health systems assessment. Processes have been put in place to ensure data collection of all measures throughout the 1815 grant cycle. Once year 1 data is available, the data will be utilized as a baseline throughout the grant to ensure an appropriate reflection of the selected health systems and pharmacies DPH is currently working with. Proposed targets are comprised of pharmacies/pharmacists and health care systems DPH is currently working with and are not reflective of the entire state of Georgia. Targets may be revised to reflect programmatic changes throughout the 5-year grant.

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Evaluation and Performance Measurement Plan

Program Title: Georgia is AHEAD: Georgia's Innovative Strategies to Advance Health Equity and Access through Diabetes Care (Category A)

Project Period: 7/30/2018 – 6/29/2023
Submitted: 1/31/2021

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Prepared by Devon Sneed & Danielle Stollar, 1817 Program Evaluators

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Recipient-Led Evaluation Plan

Introduction:

Georgia has one of the highest burdens of chronic diseases such as heart disease, stroke, and diabetes in the nation. With 10 million residents and more than 5 million cases of the seven common chronic diseases in any given year, these conditions cost the state more than 40 billion dollars per year and as a result, the Georgia Department of Public Health (DPH) has committed to, and has the experience in, addressing these conditions.

Diabetes is the seventh leading cause of death in the state and diabetes and prediabetes contribute significantly to morbidity and health care costs. In 2016, 13.9 percent of Georgia adults, or more than 1.1 million people, had diabetes with an additional 241,000 Georgia adults unaware they had diabetes. Likewise, another 36.1 percent or approximately 2,599,000 of the Georgia adult population have prediabetes, with approximately 10 percent of this population going on to develop Type 2 diabetes each year.

The prevalence of diabetes was highest among the following populations: those ages 75 and older (26.1 percent versus 2.2 percent for those ages 18-44); females (11.2 percent versus 10.3 percent in males); and individuals with less than a high school education (13.0 percent versus 9.3

percent for more than a high school education). Also, between 2000 and 2017, there were 304,305 diabetes-related hospitalizations, with an age-adjusted rate of 181.3 per 100,000 persons. Among adults ≥ 18 years, the discharge rate was highest among males (190.4 per 100,000 persons) and non-Hispanic Blacks (335.7 per 100,000 persons). The age-specific hospital discharge rate was highest among those ≥ 65 years (385.9 per 100,000 persons).

In 2017, the cost of diabetes in Georgia totaled 10.9 billion dollars per year, with direct medical costs totaling 7.8 billion dollars and lost productivity contributing to the remaining 3.1 billion dollars. Among Georgia Medicaid participants, approximately $3,200 was spent in 2012 per person diagnosed with diabetes, which resulted in Medicaid expenditures of 372.6 million dollars in that year alone.

The selection of communities and priority populations for adults with the highest risk for type 2 diabetes were previously identified based on prevalence rates of hypertension and diabetes, and high-risk socioeconomic factors influencing health. DPH will build on the successes of the 1305 funding opportunity and expand on services and partnerships in the 1815 funding opportunity to design, test, and evaluate novel approaches to addressing evidence-based strategies. These strategies are aimed at reducing risks, complications, and barriers to the prevention and control of diabetes in high burden populations. The approach for **Georgia IS AHEAD** (Georgia's Innovative Strategies to Advance Health Equity and Access through Diabetes/Hypertension care) is to catalyze and facilitate collaborative working relationships between public health and health care sectors.

Section 1.1. Overall Evaluation Approach

Strategies to Evaluate:

This comprehensive evaluation plan will follow the procedures and standards recommended by the CDC's Framework of Program Evaluation (1999). The purpose of this comprehensive evaluation is to monitor 1817 activities, determine the program effectiveness, and identify areas to strengthen program implementation. Georgia elects to rigorously evaluate strategies A3: Implement tailored communication/messaging to reach individuals at greatest risk for type 2 diabetes to increase awareness of prediabetes and the National DPP, and A6: Work with health care systems to establish or expand use of telehealth technology to increase access to diabetic retinopathy screening (using non-mydriatic retinal camera at the screening site connected to a central reading center through telemedicine).

Evaluation Approach and Context:

Georgia's 1817 program Category A will address diabetes management and type 2 diabetes prevention by implementing innovative strategies aimed at reducing risks, complications, and barriers in high burden populations. The set of evaluations will illustrate, over time, how well Georgia's proposed activities for the innovative strategic approaches are working and what modifications may be required to improve the program in order to achieve the desired end results. Guided by the CDC Framework for Evaluation, Georgia will conduct process and outcomes evaluations using the Culturally Responsive Evaluation (CRE) Framework.

CDC's Framework for Evaluation consists of six interrelated steps and standards—

- Engage stakeholders,

- Describe the program,
- Focus the evaluation design,
- Gather credible evidence,
- Justify conclusion, and
- Ensure use of evaluation results and share lessons learned. Following the CRE approach

requires that at each step of the CDC Framework, the culture, shared experience, and cultural environment of the targeted population are considered important factors. The stakeholders that are engaged and convened as members of the evaluation team must be representative of the targeted community and sensitive to the needs of the community and cultural context in which the program will be implemented. This team of stakeholders will form the evaluation team and will inform the evaluation purpose and questions, data collection and survey tools, collection timelines, interpretation of results, recommendations and dissemination of results. Thus, giving credibility to the program and implementers, and providing culturally and linguistically appropriate services.

Georgia has chosen to evaluate strategies A3 and A6. The 1817 evaluator will collect, code, analyze and interpret data from various data sources to include focus groups and key informant interviews described in the Evaluation Design and Data Collection section. The proposed data sources comprise of web-based surveys, program records, standardized reports from Floyd Medical Center, Neighborhood Improvement Project (Medical Associates Plus), and VSNS Inc., the retrieval of vital statistics data from DPH's Office of Health Indicators and Planning (OHIP), focus group discussions, key informant interviews, and key insight reports from Prevent Blindness Georgia. The Health Systems Assessment survey will be disseminated annually to assess the extent to which health systems in Georgia have polices or systems in place to support high-quality service delivery for their adult primary care patients with respect to screening and management of prediabetes, diabetes, hypertension, and cholesterol. A Partnership Survey will be dispersed annually to all stakeholders and partners to assess outcomes on efficiencies related to providing diabetic retinopathy screening to patients traditionally underserved by these programs. It will also be used to assess the strengths and weaknesses of the stakeholder workgroup. Being a critical element, the workgroup will be assessed in the following categories: environment, membership characteristics, process and structure, communication, purpose, resources and the effectiveness of the leadership provided by DPH. Key findings from surveys will be summarized and highlighted. Qualitative survey responses and data from various documents, such as program records, will be analyzed by performing descriptive data analysis and conducting thematic analyses.

The selection of communities and priority populations for adults with the highest risk for type 2 diabetes were previously identified based on prevalence rates of hypertension and diabetes, and high-risk socioeconomic factors influencing health. Evaluation efforts will focus on assessing the strategies implemented and how they contributed to a measurable change in the health, behavior, or environment of the identified communities and priority populations. The retrieval of vital statistics data from DPH OHIP will be utilized to assess key outcome variables and the program health impact by year 5. For this project, a quasi-experimental mixed methods design will be used. Analyses comparing key health outcomes prior to and post implementation and between priority populations in targeted and other areas will be conducted. The evaluator will present the preliminary findings to the Principal Investigator, 1817 Team, and other stakeholders for programmatic interpretation and to develop an action plan based on evaluation findings.

Summary briefs and reports will be shared through various channels to share findings and best practices, please see Communication/Dissemination section for further information.

Evaluation Stakeholders and Primary Intended Users of the Evaluation:

Stakeholders/partners will be involved at different levels in performance management and evaluation of the program. Primary stakeholders of the evaluation include the Centers for Disease Control and Prevention (CDC); Georgia Department of Public Health (DPH) 1817 staff; DPH, Chronic Disease Prevention, Office of Reporting and Evaluation staff; DPH Communications; DPH, related Chronic Disease Programs; DPH, Office of Health Indicators and Planning (OHIP); DPH, local Health Districts (i.e., Health Districts); participating health systems (hospitals, FQHCs, hospitals, and clinics); Georgia health systems Kidney Specialists; Association of Diabetes Care and Education Specialists (ADCES)/American Diabetes Association (ADA); Prevent Blindness Georgia, and the targeted communities. One or more representatives of our stakeholders/partners will be engaged in all phases of the evaluation process to include planning, implementation, the development of measures, data collection and interpretation as the evaluation workgroup. (**Table 1**).

Table 1: Stakeholder Assessment and Engagement Plan

Stakeholder/Partner Name	Interest or Perspective	Role in the Evaluation
CDC Project Officer	Monitor program deliverables, requirements, and performance measures	Provide technical assistance, provide data from the CDC, and planning discussions if programmatic changes are recommended
†Georgia Department of Public Health (DPH) 1817 Staff	Ensure program success through monitoring of program goals, objectives, funding, reports, and data	Guide evaluation design and implementation; use findings to inform program planning and quality improvement
DPH, Chronic Disease Prevention Section, Office of Health Science and Evaluation	Collect, analyze, and report program-specific data	Develop and implement evaluation activities, provide recommendations from findings, disseminate findings
DPH, Office of Communications	Collect, analyze, and report program-specific data	Use findings to implement and enhance the performance of the respective program
†Georgia DPH, Related Chronic Disease Programs	Collaborate and coordinate with 1817 staff to streamline chronic disease prevention efforts	Use findings to implement and enhance the performance of the respective program
Georgia DPH, Office of Health Indicators and Planning (OHIP)	Collect and report vital statistics data	Collect data and provide data; review data to ensure data reporting standards are met

†Georgia DPH, local Health Departments (i.e., Health Districts)	Implement program activities	Provide data and use evaluation findings to target services and efforts within the district
†Participating health systems (hospitals, clinics, pharmacies, FQHCs, etc.)	Receive funding and support program success by providing reports and data, and implementing interventions	Collect and provide site-level data, complete program surveys, and use evaluation results to inform planning and quality improvement
ADCES/ADA	Collect and report on DSMES and National Diabetes LCP data	Collect data and provide data
Prevent Blindness Georgia (PBGA)	Collect and report on retinopathy referrals	Collect and provide data
Representatives from the targeted community	Inform planning, implementation of interventions, and development of health communication materials to ensure culturally and linguistically appropriate	Assist with data collection, review of program materials, interpretation of results, dissemination of findings

†One or more representatives will be engaged as contributors to the evaluation workgroup

Communication/Dissemination:

Evaluation findings will be disseminated to program stakeholders and partners through various channels, such as professional statewide and national conferences and meetings, formal and informal evaluation reports, webinars, DPH website, peer-reviewed journals, evaluation briefs, and DPH public health weekly newsletter. Bi-annual progress reports and annual evaluation reports that include evaluation results, success stories about program strategies, challenges, outcomes and lessons learned and performance measures will be disseminated to program staff and CDC. Program progress and challenges will be communicated to CDC during regularly scheduled technical assistance calls. Findings will also be shared with other 1817 recipients, as well as other state, federal, and national level stakeholders interested in the 1817 funding via a webinar that will also be made available on the DPH website. Throughout the project duration, the 1817 program evaluator will submit abstracts to academic and professional conferences about the following topics: increasing awareness of prediabetes and NDPP among underserved populations through culturally competent messaging and communications; effectiveness of innovative communication strategies to reach underserved urban and rural populations; promoting early detection of diabetic retinopathy through the use telehealth in rural Georgia; and use of innovative strategies to improve the health outcomes of underserved populations. Audience, format, and channel of dissemination and responsible staff involved in the dissemination of materials are described in **Table 2.**

Table 2: Communications Plan Matrix

Audience(s)	Possible Format and Channel	Timeline	Responsibility Party
1817 Program Staff	Virtual updates on data collection and preliminary findings	Weekly	Evaluator
	In person PowerPoint presentation of evaluation findings, including feedback and action steps	Annually	Evaluator
	Email evaluation report upon completion	Annually	Evaluator
CDC	Email evaluation report upon completion	Annually (Quarter 1)	Evaluator
DPH Health Districts and participating health systems (hospitals, clinics, pharmacies, FQHCs)	In person PowerPoint presentation of evaluation findings	As Necessary, Annually	Evaluator
	PowerPoint presentation of evaluation findings via webinar and teleconference		
	Email evaluation report upon completion		
Evaluation Workgroup	PowerPoint presentation of evaluation findings via webinar and teleconference	Quarterly	Evaluator
	Email evaluation report upon completion		
DPH Chronic Disease Prevention Section Leadership and relevant program staff	Email evaluation report upon completion	Annually	Evaluator
Cross-state 1817 programs	Share evaluation findings, challenges, and strategy successes via Webinar, Virtual Community of Practice	As Necessary	Evaluator
Program stakeholders and the general public	Share synthesis of findings and lessons learned via Email, Webinar, Conferences, Report, Infographics, DPH Weekly Newsletter, Journal, Website, Press Release	Annually and Final Year of Cooperative Agreement	1817 Program Team

	Upload evaluation report on the DPH website		

Use of Evaluation Findings:

Evaluation findings will be used to ensure continuous quality and programmatic improvement by conducting bi-weekly Health Systems Staff Team Meetings that provide an opportunity for discussion on evaluation updates and the identification of successes, challenges and/or barriers during program implementation for both 1815 and 1817 cooperative agreements. In addition, the 1817 Evaluator will obtain feedback on ongoing issues related to the evaluation plan. The 1817 program evaluator will work collaboratively with the Principal Investigator, program staff and other key stakeholders to ensure that the evaluation findings will be thoroughly used for continuous quality improvement; to identify targeted recommendations and action steps and make data-based decisions, so that responsible staff can implement programmatic changes to enhance program quality, effectiveness, and efficiency. This collaboration with key program stakeholders offers the opportunity to assess whether priorities and feasibility issues hold for these focused evaluation activities and to refine these evaluation questions throughout the five-year project duration.

The 1817 evaluator will submit an annual comprehensive evaluation report to the CDC. Findings from the 1817 evaluation activities will be disseminated to program stakeholders via multiple communication methods, such as presentations at meetings, academic and professional conferences, and written documents, such as evaluation briefs, infographics, evaluation reports, and peer-reviewed journals. The evaluation findings will also be disseminated through web-based channels, such as DPH website and weekly newsletter. The 1817 program evaluator will also share the lessons learned with other national 1817 program evaluators through conference calls and webinars. We envision the results of the 1817 program will improve the science base for chronic disease care model and provide new and important information on effective strategies to implement population-wide and priority population approaches to prevent and control diabetes and heart disease and stroke.

Year 5 Health Impact:

Georgia's 1817 program plans to implement innovative strategies in communities and priority populations with a high burden of diabetes and hypertension and high-risk socioeconomic characteristics. The innovative strategies will result in increased awareness and participation in local CDC-recognized lifestyle change programs and increased diabetic retinopathy screening during the project duration. At the end of the 5-year cooperative agreement, an analysis of key health outcomes in the targeted communities and priority populations, comparing them to non-intervention communities and to state-level data will show the program's contribution to Georgia's goal to reduce hypertension and diabetes-related hospitalization and prevalence rates.

Section 1.2. Detailed Evaluation Design and Data Collection

Strategy A3 Evaluation Questions: Both process and outcome evaluations will be conducted. Evaluation types, evaluation core areas, overarching evaluation questions and relevant measures are described in **Tables 3A.3 and 3A.6**. These evaluation questions were selected and prioritized based on programmatic needs and selected evaluation purpose. The evaluator will collaborate with program stakeholders and refine these evaluation questions during the five-year project duration.

Table 3A.3: Strategy A3 Evaluation Design and Data Collection

Track and monitor measures shown to improve access to and participation and retention in the National Diabetes Prevention Program (National DPP) lifestyle change program for people with prediabetes **(Select the strategy that you will evaluate)** ***Note: if you are evaluating more than one strategy in this focus area, please provide the required information for each strategy.*** ☐**Strategy A3: Implement tailored communication/messaging to reach underserved populations at greatest risk for type 2 diabetes to increase awareness of prediabetes and the National DPP.**
Activity(s): *Provide a brief overview (e.g. 2-3 sentences) of the specific activity(s) in your work plan that you plan to evaluate.* A3. To increase the number of people that are aware of prediabetes as well as the National Diabetes LCP offerings, Georgia will implement a tailored communication campaign to reach underserved populations at the greatest risk for developing Type 2 diabetes in DeKalb and Floyd Counties using the prediabetes campaign. This tailored campaign will be implemented within a specified radius of an organization offering National Diabetes LCP. Individuals will be encouraged to complete the CDC American Diabetes Association risk assessment to calculate their prediabetes risk score. The intent of the campaign is to increase the number of individuals that are aware of their risk for prediabetes, increase the number of individuals that are aware of National Diabetes LCP offerings in their communities, and increase the number of individuals that access the resource. The prediabetes campaign and communications material were pilot tested for 2 months to inform the use of culturally and linguistically appropriate messaging and communication materials in targeted communities. Focus groups and key informant interviews will be conducted to identify key practices that facilitated tailoring of campaign components. Following the pilot campaign and focus groups, DPH plans to revamp and relaunch its prediabetes campaign. DPH will collect data and assess campaign efficacy using its newly developed Road Map of Engagement (See Appendix I).

Evaluation Questions	Indicator(s)	Data Source	Data Collection Method	Data Collection Timing	Data Analysis	Person(s) Responsible	Communication/Dissemination Strategy
What you want to know.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified objective or outcome.*	*Where you will collect the data (i.e., program records, surveys, etc.).* *List a source for each indictor.*	*How you will collect the data (i.e., abstraction from spreadsheet, database, etc.).*	*When you will collect the data (i.e., start-end date and frequency).*	*What type of analysis you will apply to the data (e.g. descriptive statistics, thematic analysis, etc.).*	*Who is responsible for collecting the data for this indicator.*	*How you will share findings (i.e., distribution products, channels, and timeline) and how findings will be used by the program.*
APPROACH							
What are best practices for effectively tailoring messaging and reaching underserved populations?	(a) # and type of priority populations (b) # / Rate of clicks through the DPH website to the CDC/ADA Risk Assessment (c) # of individuals in underserved areas reached by tailored messaging (d) Differences in approaches to tailoring messages for different priority	Program Records (a, b, e, f) DPH Communications Reports (b, e, f) Vendor Reports (c, e, f) Focus Groups (d, g, h)	Retrieved from: Program records DPH Communications reports Vendor reports Focus group response template	Per run of campaign Per focus group held	Descriptive Statistics Thematic Analysis	1817 Program Manager 1817 Evaluator DPH Communications Focus Group Facilitator	DPH 1817 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on campaign upon

	populations & target settings (e) # of culturally tailored marketing products disseminated (f) # / type of marketing & promotional activities aimed at priority populations in underserved areas (g) Which prediabetes campaign message(s) stood out the most? (h) Which message(s) have led you or people you know to take action?						completion to share findings Program stakeholders: Email summary report on campaign findings upon completion to share findings
EFFECTIVENESS							
EQ: To what extent did tailored communication/ messaging increase awareness of prediabetes and the National Diabetes LCP among	(a) # of people in underserved areas reached by tailored messaging (b) # / Rate of click throughs from vendor websites/advertisements to the DPH website	DPRP Reports (e – baseline) DPH Communications (b, c, d,) Vendor reports (a, b)	Retrieved from: DPRP Reports DPH Communications report Vendor reports Local Diabetes LCP Interviews/	Per run of campaign Quarterly (DPRP Reports) Annually, Local Diabetes LCP Landscape	Descriptive Statistics Thematic Analysis	Diabetes Prevention Program Manager Local Diabetes LCP Organizations	DPH 1817 Staff: data collection and preliminary findings will be used to inform program planning and implementation

underserved populations?	(c) # of people landing on DPH Prediabetes website & average time spent on website (d) # of clicks through the DPH website to the CDC/ADA Risk Assessment (e) # of impressions made/pages viewed with tailored messaging (f) # of people with prediabetes that enrolled in a CDC recognized lifestyle program in underserved areas compared to baseline (g) # of prediabetes referrals from campaign to Local Diabetes LCP	Local Diabetes LCPs (e, f)	Reporting Templates	Analysis/Interview/Report	Comparison Group Analysis	1817 Program Manager 1817 Evaluator	CDC Program Officer and evaluation staff: Email summary report to share findings and recommendations Program stakeholders: Email summary report to share findings
How do the National Diabetes LCP enrollment rates differ in localities targeted by tailored communication/ messaging	(a) # of people in underserved areas reached by tailored messaging (b) # of people with at least one encounter at	Vendor Reports (a) DPH Communications (a)	Retrieved from: Vendor Reports DPH Communications Reports DPRP Reports	Per run of campaign Quarterly (DPRP Reports) Annually, Local	Descriptive Statistics Thematic Analysis	Diabetes Prevention Program Manager Local Diabetes LCP Organizations	DPH 1817 Staff: data collection and preliminary findings will be used to inform program

compared to other similar localities?	a CDC recognized lifestyle program in underserved areas compared to baseline/other areas (c) # of prediabetes referrals from campaign to local Diabetes LCP (d) # of impressions made/pages viewed with tailored messaging	DPRP Reports (b – baseline) Local Diabetes LCPs (b, c)	Local Diabetes LCP (Landscape Analysis, Interviews, or Reporting Templates)	Diabetes LCP Landscape Analysis/Interview/Report	Comparison Group Analysis	1817 Program Manager 1817 Evaluator	planning and implementation CDC Program Officer and evaluation staff: Email summary report to share findings and recommendations Program stakeholders: Email summary report to share findings
IMPACT							
To what extent have tailored communications/messaging contributed to a measurable change in health, behavior, or environmental outcomes in underserved populations?	(a) # of people in underserved areas enrolled in National Diabetes LCP achieved 5-7% weight loss (b) # of participants enrolled in National Diabetes LCP who have achieved the recommended 150 minutes of exercise/week	CDC Data Link (a, b) Hospital Surveillance data (c) Local Diabetes LCPs (a, b, d)	Retrieved from: CDC Data Link Local Diabetes LCP (Landscape Analysis, Interviews, or Reporting Templates); Health Systems Assessment (hospitalization discharge,	As available (CDC Data Link) Annually, Health Systems Assessment; Local Diabetes LCP Landscape Analysis/Interview/Report;	Comparative Analysis (t-test & chi-square test)	Diabetes Prevention Program Manager 1817 Program Manager 1817 Evaluator Health Systems/1815 Evaluator	DPH 1817 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary

	compared to baseline/other areas (c) Surveillance Data: Hospitalization discharge rates, emergency room rates, mortality rates compared to baseline/other areas (d) # of referrals to local Diabetes LCP in underserved areas	HRSA (c) DPH OASIS (c)	emergency room, & mortality data) HRSA database DPH OASIS database	HRSA; OASIS			report to share findings and recommendations Program stakeholders: Email summary report to share findings

Table 3A6: Strategy A6 Evaluation Design and Data Collection

Track and monitor measures shown to improve access to and participation and retention in the National Diabetes Prevention Program (National DPP) lifestyle change program for people with prediabetes
(Select the strategy that you will evaluate) ***Note: if you are evaluating more than one strategy in this focus area, please provide the required information for each strategy.***

☐Strategy A6: Work with health care systems to establish or expand use of telehealth technology to increase access to diabetic retinopathy screening (using non-mydriatic retinal camera at the screening site connected to a central reading center through telemedicine)

Activity(s): *Provide a brief overview (e.g. 2-3 sentences) of the specific activity(s) in your work plan that you plan to evaluate.*

In partnership with DPH, Prevent Blindness Georgia (PBGA), Floyd Medical Center (Floyd), Neighborhood Improvement Project (Medical Associates Plus), and VSNS Inc. will increase the availability of diabetic retinopathy screening via telehealth to residents throughout Georgia. PBGA will provide technical assistance to Floyd, Medical Associates Plus, and VSNS Inc. staff on proper techniques to obtain readable retinal scans with a handheld retinal camera. Staff will also be trained on the transmission of images to trained Ophthalmologists for reading and report creation.

Evaluation Questions	Indicator(s)	Data Source	Data Collection Method	Data Collection Timing	Data Analysis	Person(s) Responsible	Communication/ Dissemination Strategy
What you want to know.	*A specific, observable, and measurable characteristic or change that shows progress toward achieving a specified objective or outcome.*	*Where you will collect the data (i.e., program records, surveys, etc.).* *List a source for each indictor.*	*How you will collect the data (i.e., abstraction from spreadsheet, database, etc.).*	*When you will collect the data (i.e., start-end date and frequency).*	*What type of analysis you will apply to the data (e.g. descriptive statistics, thematic analysis, etc.).*	*Who is responsible for collecting the data for this indicator?*	*How you will share findings (i.e., distribution products, channels, and timeline) and how findings will be used by the program.*

APPROACH							
What is the number of sites using telemedicine for delivery of diabetic retinopathy screening?	(a) # of screening sites	Program records (a)	Retrieved from: Program records	Annually	Descriptive Statistics and Thematic Analysis	1817 Program Manager 1817 Evaluator	DPH 1817 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report to share findings and recommendations Program stakeholders: Email summary report to share findings

What were the barriers or facilitators for delivery of diabetic retinopathy screening using telehealth? (i.e. technology challenges, participant engagement/retention challenges, or training and development challenges)	(a) # of diabetic retinopathy screening sites established in underserved areas and connected to a telemedicine reading center (b) Barriers and facilitators for delivery of diabetic retinopathy screening using telehealth (c) How are barriers addressed?	Program records (a) Partner reports (b, c) Satisfaction Survey (b)	Retrieved from Program records Partner reporting templates Satisfaction Survey Responses	Annually, Program Records Quarterly, Partner Reports, Satisfaction Survey	Descriptive Statistics Thematic Analysis	1817 Program Manager 1817 Evaluator	DPH 1817 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report to share findings and recommendations Program stakeholders: Email summary report to share findings
EFFECTIVENESS							
EQ: How effective has DPH 1817-funded activities been in providing diabetic retinopathy screenings via telehealth to improve access	(a) Types of shared partnerships leveraged to support use of telehealth to increase diabetic retinopathy screening in underserved areas	Program records Quarterly Progress reports BRFSS	Retrieved from: Program records Quarterly/annual progress reports BRFSS	Annually, Program Records, (BRFSS data?) Quarterly, Partner Reporting Templates,	Descriptive Statistics; pre/post-test design analysis and Thematic Analysis	Diabetes Prevention Program Manager, Diabetes Management Coordinator; Evaluator	DPH 1817 Staff: data collection and preliminary findings will be used to inform program planning and implementation

to patients traditionally underserved?	(b) Types of leveraged resources across screening sites (c) Knowledge/attitude toward telehealth screening among priority populations (d) Diabetic screening rates among telehealth participants compared to face to face			Satisfaction Survey Response			CDC Program Officer and evaluation staff: Email summary report on Health System Assessment upon completion to share findings Program stakeholders: Email summary report on Health System Assessment upon completion to share findings
IMPACT							
EQ: What is the impact of telehealth on health promotion and increasing diabetic retinopathy screenings in traditionally underserved areas?	(a) # of telehealth patients with diabetes screened for diabetic retinopathy (b) # of usable retinal images obtained (c) % of telehealth patients diagnosed with diabetic retinopathy	Program records Quarterly progress reports Retinopathy Screening Satisfaction Survey responses	Retrieved from: Program records Quarterly/annual progress reports Retinopathy Screening Satisfaction Survey	Annually	Descriptive Statistics	Diabetes Prevention Program Manager Diabetes Management Coordinator Evaluator	DPH 1817 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Health

	(d) % of individuals who understand the importance of taking an active role in one's health						System Assessment upon completion to share findings Program stakeholders: Email summary report on Health System Assessment upon completion to share findings
EQ: How have 1817 funded activities ensured that target population is being reached?	(a) % of individuals uninsured/underinsured (b) To which ethnicity/race do individuals most identify? (c) % of individuals who have health insurance (d) Knowledge of /attitude toward telehealth diabetic screening availability for priority populations	Retinopathy Screening Satisfaction Survey responses	Retrieved from: Retinopathy Screening Satisfaction Survey	Annually	Descriptive Statistics	Diabetes Prevention Program Manager Diabetes Management Coordinator Evaluator	DPH 1817 Staff: data collection and preliminary findings will be used to inform program planning and implementation CDC Program Officer and evaluation staff: Email summary report on Health System Assessment upon completion to share findings Program stakeholders:

							Email summary report on Health System Assessment upon completion to share findings

Section 2. Performance Measurement Plan

Overall Performance Measurement Approach:

Table 3. Performance Measurement Plan

	Performance Measurement Plan Narrative
	How will the quality of performance measure data be assured? The quality of the performance measure data will be assured with the creation of standardized data collection tools and the use of Catalyst, the statewide reporting system utilized both internally and externally and the continuous monitoring of data collection by the 1817 Evaluator. The Evaluator will ensure technical assistance is provided to all individuals who collect and report data that feed into the 1817 Category A performance measures. In addition, data will be presented to 1817 staff on a monthly, quarterly, and annual basis to facilitate feedback on evaluation components, program quality improvement, and decision making.
	How will performance measurement yield findings to demonstrate progress towards achieving program goals? The performance measurement will yield findings to demonstrate progress towards achieving goals by the collection and analysis of real-time data on a monthly, quarterly, and annual basis that focuses on activities related to community-clinical linkage and health systems change to reduce the burden of diabetes in the state of Georgia through the promotion and use of evidence-based strategies.
	How will performance measure data be disseminated? The performance measure data will be disseminated through various channels, such as local and national conferences, meetings, evaluation reports, DPH website, peer-reviewed journals, evaluation briefs and National Diabetes LCP weekly newsletter. The 1817 team will present the evaluation findings to other 1817 states and local, state, and national level stakeholders through reports and conference calls. Additionally, fact sheets on the latest data and literature on the use of telehealth to promote an increase in diabetic retinopathy screening in underserved areas will be developed and may include performance measure data.

	Additional Narrative Nine of Georgia's 159 counties were selected for 1817 interventions (Crisp, Clarke, Clayton, DeKalb, Dougherty, Floyd, Fulton, and Richmond) based on high disease burden, high-risk socioeconomic characteristics, and existing collaborations. Category A interventions have targeted priority populations in DeKalb, Floyd and Richmond counties. Floyd (12.9%) has a higher prevalence of diabetes than Georgia overall (11.4%) and the US overall (9.1%). With respect to racial disparities, DeKalb County has one of the highest percentages of African American population in Georgia at 55.3%. and African Americans in Georgia have the highest prevalence of hypertension, diabetes, and obesity compared to other race and ethnicity groups in Georgia. The poverty level DeKalb (17.5%) County is higher than Georgia's state poverty level of 16%. In addition, within DeKalb County, there are cities with even higher concentrations of poverty than the county or state levels, such as Clarkston (44%), Decatur (28%), Doraville (25%) and Stone Mountain (23%). Finally, the uninsured population in Floyd (18%) county is higher than that of the state of Georgia (16%). Following the initial pilot of a pre-diabetes campaign in Floyd and DeKalb counties, DPH will revamp its campaign using data insights and feedback from the pilot and relaunch the campaign in the same counties in year 3. With the work under 1815 expanding the availability of National Diabetes LCP across the state, we expect that in years 2-5 we will have several locations that will benefit from this campaign to increase engagement in National Diabetes LCP and awareness of prediabetes in the community. Richmond (13%) has a higher prevalence of diabetes than Georgia overall (11.4%) and the US overall (9.1%). When considering education, the percentage of the population with less than high school education in Richmond (21%) county is higher than the state average of 17%. In addition, the percentage of households experiencing overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities in Richmond (21%) is higher than the state average of 17%. Following the initial diabetic retinopathy screenings at Floyd Medical Center Locations, DPH will expand the retinal screening to other high-risk regions of the state. In year 2, DPH expanded retinal screenings to Richmond County by working with its partner, the Neighborhood Improvement Project dba Medical Associates Plus. In year 3, DPH plans to expand retinal screenings to Crisp, Dougherty, Dekalb, and Fulton counties by working with partners, such as VSNS Inc. and others. DPH will continue to leverage state vision funds and partner with Prevent Blindness Georgia (PBGA) to provide training to staff in additional locations, increasing the organizational capacity for other locations to provide screening services. Throughout the remainder of the grant, we expect to expand the retinal screenings to at least one additional health system in our targeted county.

Appendix I: DPH Prediabetes Communications Campaign, Road Map of Engagement