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Cardiovascular Health Program

2023-2024 Evaluation and Performance Management Plan

Chronic Disease Prevention Section
Medical and Clinical Service Division
Georgia Department of Public Health

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Evaluation and Performance Measurement Plan

2304 The Georgia Cardiovascular Health Program

Project Period: *6/30/2023 – 6/29/2028*

Year 1 Evaluation and Performance Measure Plan

Reporting Period:

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Prepared by:

Syreeta Wainaina - Program Evaluator, Emma Bicego - Sr. Deputy Director, Patsy Sarnor - Program Lead, Camille Watson - Program Manager, Monyette Childs - Deputy Director, and Kia Toddle - Director and Principal Investigator – Chronic Disease Prevention Section, Georgia Department of Public Health

Introduction:

Cardiovascular disease (CVD) is a leading cause of death in the United States, claiming one life every 34 seconds and resulting in 697,000 deaths in 2020. In Georgia, CVD is the primary cause of mortality, with over 29,200 deaths reported in 2021. Vital records show that 25% of Georgians who died from CVD were below 65. Despite interventions like lifestyle changes and medications, CVD remains the top cause of death across racial and ethnic groups, as well as among men and women in both Georgia and the U.S. Six out of ten Americans suffer from at least one chronic disease, such as heart disease, a major contributor to healthcare costs and disability. Georgia records over 5 million cases of the seven most common chronic diseases annually, highlighting a significant burden. Addressing CVD is crucial for mitigating its impact on public health.

The Cardiovascular Health Program is poised to spearhead interventions and foster collaborations among key stakeholders to alleviate the burden of cardiovascular disease in Georgia. With a focus on high-burden areas, the program prioritizes partnerships with clinics and healthcare systems. The goal is to address social and economic factors within communities, ensuring optimal health outcomes for individuals at risk of or affected by cardiovascular disease (CVD).

The cardiovascular health team will concentrate efforts on clinics and healthcare systems within high-burden areas. These areas encompass communities characterized by specific social and economic factors. The aim is to empower communities and health systems to respond effectively to the social determinants present, thereby enhancing health outcomes for individuals at risk of or burdened with CVD.

The program will leverage a logic model, as outlined in Appendix A, to guide Georgia's planned Evaluation Design and Data Collection. This framework will ensure a systematic approach to interventions and assessments, allowing for a comprehensive understanding of the program's impact on reducing the burden of cardiovascular disease.

By fostering partnerships and collaborations, the Cardiovascular Health Program seeks to create a supportive environment for addressing social determinants within communities. This collaborative approach aims to enhance the capacity of clinics and healthcare systems to respond effectively to the unique needs of populations at risk of cardiovascular disease.

Recognizing the influence of social determinants, the program aims to equip communities and health systems with the tools to respond proactively. By addressing underlying social and economic factors, the program endeavors to contribute to improved health status and outcomes for individuals affected by cardiovascular disease.

The Cardiovascular Health Program's commitment to strategic interventions, collaborative partnerships, and a comprehensive evaluation framework underscores its dedication to mitigating the impact of cardiovascular disease in Georgia.

Narrative of the Evaluation Approach

Evaluation Approach and Context:

The Georgia Department of Public Health (DPH) 2304 program aims to prevent and manage cardiovascular disease (CVD) through a 5-year cooperative agreement. Working with diverse local partners, the program targets populations at higher risk, focusing on those with undiagnosed or uncontrolled high blood pressure and cholesterol, especially in areas with disparities and inequalities.

The evaluation approach employs a mixed methods strategy, combining quantitative and qualitative methodologies. Data collection sources include surveys, program records, reports from partners, vital statistics from DPH, and annual reports from the Health Resources Services Administration on Federally Qualified Health Centers. An annual Health Systems Assessment and Partnership Survey will gauge the impact on health systems and stakeholder outcomes.

Key evaluation efforts center on assessing the implemented strategies' contribution to measurable changes in the health, behavior, and environment of the identified communities. Vital statistics data will be used to evaluate outcomes and health impact by year 5, stratifying by demographics. Preliminary findings will be presented to stakeholders, and an action plan based on evaluation results will be developed.

The program's extensive network of partners, including healthcare systems, public and private organizations, and FQHCs, supports the implementation of strategies. The collaboration aims to transform systems and establish community clinical linkages, ultimately improving health outcomes in Georgia. Findings and best practices will be disseminated through various channels to enhance programmatic interpretation and inform future initiatives.

Evaluation Partners and Primary Intended Users of the Evaluation:

The primary stakeholders for the evaluation include CDC Project Officers and the Georgia Department of Public Health (DPH), specifically the 2304 Cardiovascular Health Program Staff, which encompasses the Office of Health Indicators and Planning (OHIP), local Health Departments (Health Districts), and CVD partners. These stakeholders will play integral roles at different stages of data collection, performance management, and program evaluation.

The engagement of stakeholders/partners is emphasized, seeking their input on data collection methods and tools. Any recommendations for enhancement will be carefully considered and shared with the involved stakeholders. The CDC Project Officer will utilize evaluation results to provide technical assistance and engage in planning discussions in case programmatic changes are

recommended. The DPH 2304 staff will use the evaluation findings to shape program planning and contribute to ongoing quality improvement efforts.

At the local level, DPH Health Departments can leverage evaluation findings to target services and allocate resources more effectively within their respective districts. Communication channels such as email, webinars, and conference calls will be employed to engage selected stakeholders and program staff throughout various phases of the evaluation process. This inclusive approach ensures that the evaluation results are not only disseminated but actively used to enhance program outcomes and decision-making at multiple levels of the organizational hierarchy.

In Year 5. Health Impact:

In Year 5 of the 5-year cooperative agreement, the Georgia 2304 program anticipates significant health impact through the attainment of its overarching goals. The program's key objectives for this period include:

1. Clinical Data Enhancement: A targeted increase in reporting, monitoring, and tracking of clinical data is expected. This initiative aims to improve the process of identification, management, and treatment of patients grappling with high blood pressure and high blood cholesterol.
2. Community Clinical Links Strengthening: The program envisions an increase in community clinical links. These links are designed to support systematic referrals, foster self-management, and encourage lifestyle changes for individuals dealing with high blood pressure and high blood cholesterol.

Georgia's CVD program, aligned with these overarching goals, seeks to achieve the following specific outcomes in Year 5:

1. Improved Health Metrics: The program aims to increase blood pressure control and decrease cholesterol levels among populations within partner health care and community settings, signifying a tangible improvement in overall health outcomes.
2. Disparities Reduction: A concerted effort will be made to reduce disparities in blood pressure control, particularly focusing on populations within partner health care and community settings. This initiative addresses health inequalities and promotes equitable health outcomes.
3. Social Support Augmentation: The program aspires to increase the utilization of social services and support, specifically targeting populations at the highest risk of CVD. The focal point remains on hypertension and high blood cholesterol, addressing critical aspects of cardiovascular health.

By concentrating on these multifaceted goals, the Year 5 objectives aim to culminate in a substantial and positive health impact, reflecting advancements in clinical data management, community linkages, and overall cardiovascular health outcomes.

ENSURE USE OF EVALUATION FINDINGS

To ensure that the program evaluation will facilitate the use of evaluation findings, a dissemination plan will be developed in conjunction with the evaluation plan. Evaluation findings will be synthesized into an evaluation action plan, developed in collaboration with stakeholders/partners. The action plan will detail targeted recommendations and specific action steps necessary to implement the recommendations for program improvement. As an action-oriented management tool, the evaluation findings will be intended to inform program planners and stakeholders of opportunities to strengthen, enhance, and revise program activities.

Table 1. Strategy-Specific Evaluation Design and Data Collection

Strategy 1: Track and Monitor Clinical and Social Services and Support Needs Measures Shown to Improve Health and Wellness, Health Care Quality, and Identify Patients at the Highest Risk of Cardiovascular Disease (CVD) with a Focus on Hypertension and High Cholesterol.

Approach 1A: Advance the adoption and use of electronic health records (EHR) or health information technology (HIT), to identify, track, and monitor measures for clinical and social services and support needs to address health care disparities and health outcomes for adults at the highest risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol.

Activity(s):

Activity #1: Partner with Georgia Primary Care Association (GPCA) to recruit two FQHCs that use eClinical Works electronic health record (EHR) to identify, track, and monitor measures for clinical and social services and support needs to address health care disparities and health outcomes for adults at highest risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol.

Activity #2: Partner with GPCA to develop a new customized CATAPULT plan for QI interventions in 2 FQHCs to identify, track, and monitor measures for clinical and social services and support needs. Identify disparities in outcomes for patients with hypertension and high cholesterol, by race, ethnicity, and other populations of focus. CATAPULT plan will include required EHR training for the clinical team.

Communication/Dissemination Strategy: The evaluation findings will be shared through various channels, such as local and national conferences, meetings, evaluation reports, the DPH website, and CDC Evaluation Reports. The 2304 team will be responsible for presenting the evaluation findings to other 2304 states and local, as well as state and national level stakeholders through reports and conference calls. Information will be tailored to each audience and mode of dissemination.

Evaluation Question	Indicator/ Performance Measure	Method	Data Source	Frequency	Responsibility
Effectiveness: To what extent has the adoption and use of EHR	• Percentage increase in EHR adoption in recruited FQHCs	**Quantitative Analysis:** Collect and analyze	Program Records Quarterly Reports	Annually	Evaluator

or health information technology (HIT) facilitated the identification, tracking, and monitoring of clinical and social services for adults at the highest risk of cardiovascular disease (CVD)?	• Disparities reduction in health outcomes across diverse populations, and the identification of targeted interventions.	quantitative data from EHRs, patient records, and health outcome metrics. **Surveys and Interviews:** Conduct surveys and interviews with clinical teams and stakeholders to gather qualitative insights on the effectiveness of EHR utilization, recruitment, and intervention strategies. **Document Review:** Review CATAPULT plans, training materials, and reports to assess the implementation of QI interventions and disparities identification.	Health Systems Assessment Survey HRSA: Health Resources and Services Administration		
How successful is the partnership with GPCA in recruiting FQHCs for EHR utilization to identify, track, and monitor measures related to clinical and social services for adults at the highest risk of cardiovascular disease (CVD)?	• # of FQHCs recruited and successfully engaged in the initiative. • Percentage of patient records in eClinical Works with relevant CVD measures. • Number of clinical measures tracked. • Number of social services tracked.			Quarterly and Annually	Evaluator
To what extent is the CATAPULT plan implemented in FQHCs for QI interventions?	• Completion rate of CATAPULT plan components. • # of patients identified by characteristics and outcomes. • Action plans developed to address disparities.				
How effective is the EHR training for the clinical team?	• Level of participation and engagement of the clinical team in the EHR training. • Improvement in clinical team				

	proficiency with EHR.				

Approach 1B: Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.

Activity(s):

Activity #1: Partner with Georgia Primary Care Association (GPCA) to assess tools and processes used to identify social services and support needs of patients, refer patients to social and support services, and track utilization of those services. Provide user access to findhelp.org to up to 5 FQHCs.

Activity #2: Partner with GPCA and Community Health Worker Program and provide user access for up to 5 FQHCs to use FindHelp.org (social care technology systems) to track referrals and utilization of social services.

Communication/Dissemination Strategy: The evaluation findings will be shared through various channels, such as local and national conferences, meetings, evaluation reports, the DPH website, and CDC Evaluation Reports. The 2304 team will be responsible for presenting the evaluation findings to other 2304 states and local, as well as state and national level stakeholders through reports and conference calls. Information will be tailored to each audience and mode of dissemination.

Evaluation Question	Indicator/ Performance Measure	Method	Data Source	Frequency	Responsibility
Effectiveness: How effective is Approach 1B in promoting the use of standardized processes or tools to identify social services and support needs, and monitor and assess the referral and utilization of those services for patient populations at the highest risk of CVD?	• Adoption rate of standardized processes and tools. • Improvement in patient outcomes.	**Surveys and Interviews:** Conduct surveys and interviews with FQHC staff, and Community Health Workers to gather qualitative insights on the effectiveness of tools, processes, and the impact of FindHelp.org on social services utilization. Discuss	Program Records Health Systems Assessment Survey in Qualtrics HRSA: Health Resources and Services Administration	Annually	Evaluator

How comprehensive and suitable are the tools and processes assessed by GPCA for identifying social services and support needs?	• Number of tools and processes assessed. • Ratings of assessed tools and processes by FQHCs.	challenges and successes in implementing FindHelp.org. **Usage Metrics Analysis:** Collect usage metrics from FindHelp.org, including the number of referrals made, and utilization of social services. Analyze trends over time to assess the adoption and impact of the resource. **Quality Assessment:** Assess the quality of tools and processes identified by GPCA through reviews and feedback from FQHCs.			
To what extent do FQHCs adopt and utilize FindHelp.org after user access is provided?	• Number of FQHCs using FindHelp.org. • Frequency of use and referrals made through FindHelp.org.			Quarterly and Annually	Evaluator
How effective is the partnership with the Community Health Worker Program in enhancing the utilization of FindHelp.org for tracking referrals and social services utilization?	• Number of Community Health Workers trained and actively using FindHelp.org. • Increase in the accuracy of tracking referrals and service utilization.				
How accurate is the tracking of referrals and utilization of social services using FindHelp.org?	• Percentage of tracked referrals leading to service utilization. • Feedback from patients and service providers on the accuracy of tracking.				
Strategy 2: Implement Team-Based Care to Prevent and Reduce CVD Risk with a Focus on Hypertension and High Cholesterol Prevention, Detection, Control, and Management through the Mitigation of Social Support Barriers to Improve Outcomes. **Approach 2C:** Build and manage a coordinated network of multidisciplinary partnerships that address identified barriers to social services and support needs (e.g., childcare, transportation, language translation, food assistance, and housing) within populations at the highest risk of CVD.					

Activity(s): **Activity #1:** Partner with TBD to assemble and convene a multidisciplinary Georgia Learning Collaborative (LC).					
Communication/Dissemination Strategy: The evaluation findings will be shared through various channels, such as local and national conferences, meetings, evaluation reports, the DPH website, and CDC Evaluation Reports. The 2304 team will be responsible for presenting the evaluation findings to other 2304 states and local, as well as state and national level stakeholders through reports and conference calls. Information will be tailored to each audience and mode of dissemination.					
Evaluation Question	**Indicator/ Performance Measure**	**Method**	**Data Source**	**Frequency**	**Responsibility**
To what extent was the Georgia Learning Collaborative (LC) successfully formed and functional in addressing identified barriers to social services and support needs?	• Timely assembly of the LC. • Level of participation and engagement from diverse disciplines.	**Documentation and Record Review:** Review meeting minutes, records, and documents related to the assembly, discussions, and activities of the Georgia Learning Collaborative. **Surveys and Interviews:** Conduct surveys and interviews with members of the LC to gather feedback on the formation process, functionality, and perceived effectiveness of partnerships. Stakeholder **Outcome Monitoring:**	Program Reports HRSA: Health Resources and Services Administration	Quarterly and Annually	Evaluator and Contactors
How effective were the multidisciplinary partnerships in addressing identified barriers and enhancing social support for populations at the highest risk of CVD?	• Number of partnerships formed. • Quality of collaboration as perceived by partners.				
To what extent did the LC successfully identify barriers to social services and support needs within populations at the highest risk of CVD?	• Comprehensive list of identified barriers. • Stakeholder agreement on priority barriers.				

How well did the LC develop and implement action plans and interventions to address the identified barriers?	• Existence of action plans. • Level of implementation of interventions.	Regularly monitor the progress of action plans and interventions through documented milestones and reports.			

Strategy 3: Link Community Resources and Clinical Services That Support Bidirectional Referrals, Self-Management, and Lifestyle Change to Address Social Determinants That Put the Priority Populations at Increased Risk of Cardiovascular Disease with a Focus on Hypertension and High Cholesterol.

Approach 3A: Create and/or enhance community-clinical links to identify SDoH (e.g., housing, transportation, access to care, and community resources) and respond to the individual social support needs of populations at highest risk of cardiovascular disease with a focus on hypertension.

Activity(s):
Activity 1. Partner with GPCA to formulate an analysis of select FQHCs' policies and procedures based on patient satisfaction surveys.
Activity 2. Partner with GPCA to coordinate training opportunities for FQHC staff on the PRAPARE assessment tool to identify and facilitate referrals to social services in FQHCs.
Activity 3. Building on work from 1815 to increase referrals to community programming, participating in Federally Qualified Health Centers (FQHCs), will address food insecurities and food access by establishing community linkages to Project Open Hand and Wholesome Wave Georgia.
Activity 4. Invite partners implementing activities related to Community-Clinical linkages to participate in the Learning Collaborative to facilitate communication and exchange of ideas. Partners will receive assistance in using data to create maps to identify census tracts with priority populations at the highest risk for cardiovascular health conditions, based on CVD burden and social factors, environmental structures, and healthcare structures that impact priority populations.

Communication/Dissemination Strategy: The evaluation findings will be shared through various channels, such as local and national conferences, meetings, evaluation reports, the DPH website, and CDC Evaluation Reports. The 2304 team will be responsible for presenting the evaluation findings to other 2304 states and local, as well as state and national level stakeholders through reports and conference calls. Information will be tailored to each audience and mode of dissemination.

Evaluation Question	**Indicator/ Performance Measure**	**Method**	**Data Source**	**Frequency**	**Responsibility**
Effectiveness: How effective is this strategy in creating and enhancing community-	• Number of established community-clinical links. • Improvement in patient-reported	**Survey and Focus Group Analysis:** Analyze responses from patient surveys	Program Records HRSA: Health Resources and Services	Annually	Evaluator

clinical links to address social determinants and respond to social support needs for populations at the highest risk of cardiovascular disease (CVD)?	assessments of social and medical needs.	to assess the effectiveness of patient assessments and the impact on social and medical needs. **Policy and Procedure Review:** Review analyzed policies and procedures to identify areas for improvement and assess the impact on patient satisfaction. **Training Evaluation:** Evaluate the adoption of the PRAPARE tool through pre- and post-training	Administration		
To what extent does the partnership with GPCA in analyzing FQHCs' policies and procedures (based on patient satisfaction surveys) contribute to identifying areas for improvement?	• Number of policies and procedures analyzed. • Identified areas for improvement based on analysis.			Quarterly, Annually	
How well do FQHCs adopt and utilize the PRAPARE assessment tool to identify and facilitate referrals to social services?	• Percentage of FQHC staff trained. • Number of referrals made through the PRAPARE tool.				

To what extent does the partnership with community programs and Project Open Hand/Wholesome Wave Georgia address food insecurities and improve food access for priority populations?	• Number of referrals made to community programs. • Improvement in food access metrics.	assessments, and track referrals made using the tool. **Community Program Impact Analysis:** Monitor and analyze the impact of community programs and partnerships with Project Open Hand/Wholesome Wave Georgia on food insecurities and access.			
Approach 3B: Identify and deploy dedicated CHWs (or their equivalents) to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.					
Activity 2. Provide support for the Community Health Worker (CHW) Network, to provide opportunities for CHWs to collaborate through meetings and learning collaboratives that support peer learning exchanges and collaborative partnerships. The partner will provide administrative support, and assist with the steering teams, regional, and statewide Georgia CHW Network meetings.					
Communication/Dissemination Strategy: The evaluation findings will be shared through various channels, such as local and national conferences, meetings, evaluation reports, the DPH website, and CDC Evaluation Reports. The 2304 team will be responsible for presenting the evaluation findings to other 2304 states and local, as well as state and national level stakeholders through reports and conference calls. Information will be tailored to each audience and mode of dissemination.					
To what extent does the support provided for the CHW Network facilitate	• Number of CHWs participating in meetings and learning collaboratives.	**CHW Network Participation Analysis:** Analyze attendance	HRSA: Health Resources and Services	Quarterly	Evaluator

collaboration and peer learning exchanges among CHWs?	• Quality of collaborative partnerships established.	records, feedback, and collaboration outcomes from CHWs participating in meetings and learning collaboratives to assess the effectiveness and quality of the support provided.	Administration Program Records		

Stakeholder engagement

Stakeholders/partners will be involved at all different levels in performance management and evaluation of the program. Key partners and program staff will be engaged in all phases of the evaluation process including planning, implementation, and the development of measures. Table 2. provides a list of partners/stakeholders, their role in the evaluation, and how and when to engage them. Georgia will engage different stakeholders to assess stakeholder/partner readiness and find out to what extent they are engaging our priority populations.

Table 2: Stakeholder engagement

Stakeholder Name	Stakeholder Category	Interest or Perspective	Role in the Evaluation	How and When to Engage
CDC Project Officer	Primary	Monitor program deliverables, requirements, and performance measures	Development of Evaluation plan; Provide technical assistance, provide data from the CDC, and plan discussions if programmatic changes are recommended. Data collection and analysis	Interpretation of findings; Use evaluation findings in monthly meetings and quarterly, and annual progress reports, and assistance via email

Georgia Department of Public Health (DPH) 2304 Staff	Primary	Ensure program success through monitoring of program goals, objectives, funding, reports, and data	Development of Evaluation plan; Guide evaluation design and implementation, use findings to inform program planning and quality improvement. Data collection	Interpretation of findings. Use evaluation findings in bi-weekly meetings, and monthly and quarterly reports.
DPH Chronic Disease Prevention Section Reporting and Evaluation Office	Primary	Collect, analyze, and report program-specific data	Lead evaluation activities, develop and implement evaluation plan and reports, analyze program data, provide recommendations from findings, disseminate findings	Dissemination of findings The evaluation is used in bi-weekly meetings and monthly and quarterly reports.
DPH Related Chronic Disease Programs, Georgia Primary Care Association	Secondary	Collaborate and coordinate with 2304 staff to streamline chronic disease prevention efforts	Use findings to implement and enhance the performance of a respective program.	Use and dissemination of evaluation findings in quarterly reports.
DPH Office of Health Indicators and Planning (OHIP), Chronic Disease, Health Behaviors, & Injury Epidemiology Section	Secondary	Collect and report vital statistics data	Provide and collect data	Quarterly reports
DPH local Public Health Districts, DPH	Tertiary	Implement program activities	Provide and collect data and use evaluation findings to target	Dissemination of

Communications, Select FQHCs, Metro Atlanta Ministerial Alliance, Heal Collaborative, Ready Set Push, Georgia State University			services and efforts within the districts Use and dissemination of evaluation findings	evaluation findings in monthly and annual reports
Community Pharmacy Enhanced Service Network (CPESN), Georgia Pharmacy Association	Tertiary	Collect and report on expansion, billing, and referrals of cardiovascular disease control and prevention programs in pharmacy	Collect data and provide data Use and dissemination of evaluation findings	Dissemination of evaluation findings in monthly and annual reports

DATA ANALYSIS

The evaluation will combine both quantitative and qualitative methods. The proposed methods include the use of statistical analysis to assess key metrics such as CVD risk factors, health outcomes, and program adoption rates. Qualitative methods, including interviews, focus groups, and thematic analysis, will provide in-depth insights into the effectiveness and impact of the strategies. Continuous monitoring processes, stakeholder engagement, and the application of mixed-methods integration are recommended for ongoing improvement and validation of findings. Data visualization techniques will be employed to enhance the communication of key trends and insights. This multifaceted methodology aims to provide a comprehensive understanding of the strategies' effectiveness and guide informed decision-making for program adjustments and enhancements.

The evaluator will compile, clean, code, analyze, and interpret data from multiple data sources. The evaluator will summarize and highlight the key findings from the monthly and quarterly progress reports submitted by partners implementing the strategies. Some key outcome variables will be stratified by demographics, such as age, race/ethnicity, and geographic region.

Table 3: Key Project Activities Reporting Timeline, CDP 2023 - 2029

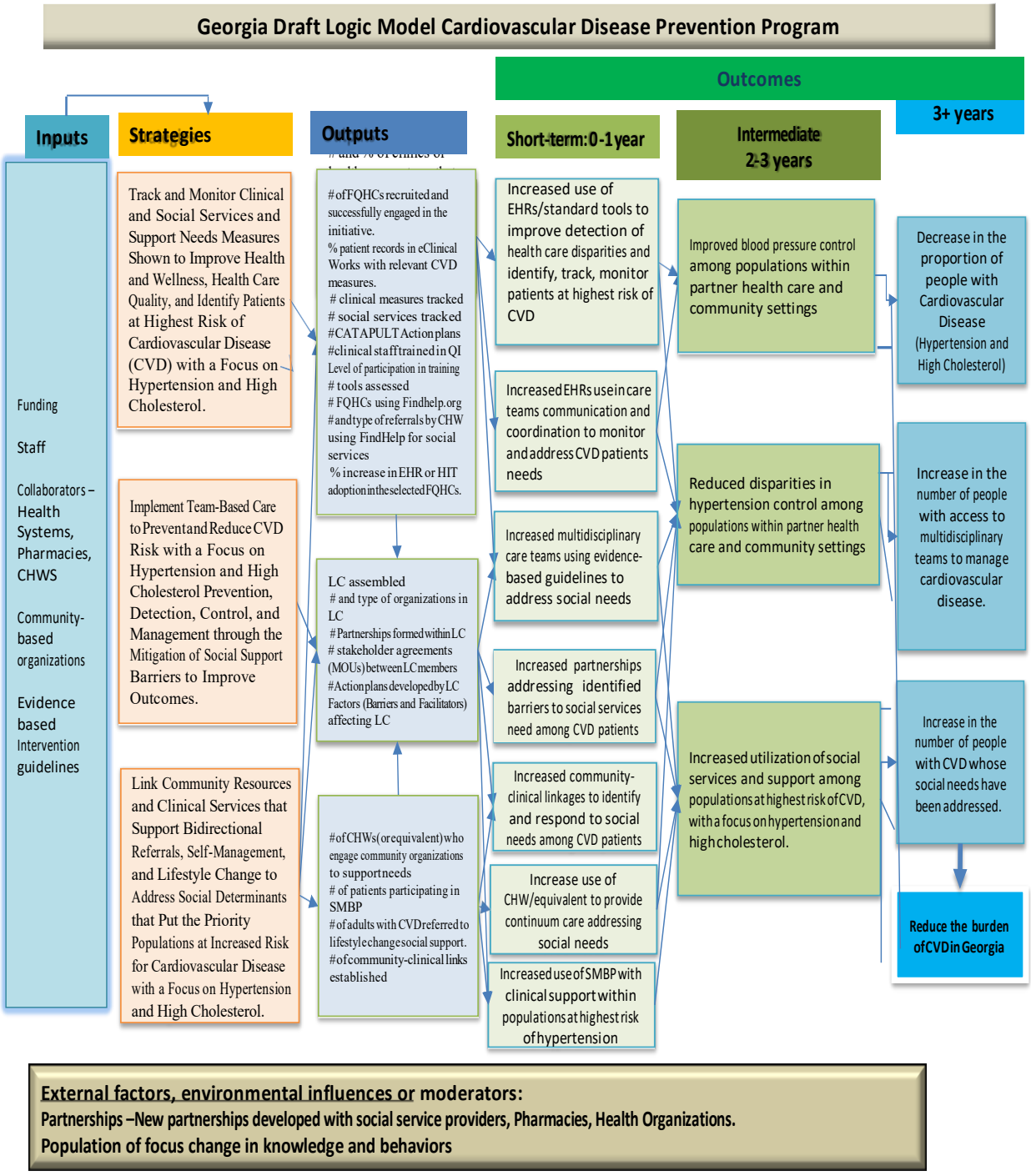
Timeline	Key Activities
Y1: 1st and 2nd. Quarter	Evaluation and performance measurement planning phase; The Evaluation and Surveillance staff and workgroup will collaborate with the CDC Evaluation and surveillance unit to develop a more detailed evaluation and performance measurement plan.
Y1: 3rd Quarter	Finalize evaluation and performance measurement plan; Develop data collection, data analysis, dissemination, and communication plan.
Y1: 3rd & 4th Quarter	Data collection from all funded implementers including progress, barriers, and facilitators to implementation, data collection/entry/submission.
Y2 – Y5	
Q1	Submission of year 1 annual progress report to CDC Submission of a progress report by funded implementers. Dissemination of the previous year's progress report to stakeholders Collect quarterly progress data from partners.
Q2	Collect progress data from partners. Dissemination of the previous quarter's progress report to stakeholders
Q3	Submit interim performance report to CDC Collect quarterly progress data from partners
Q4	Data collection from all funded implementers; Data collection from all funded implementers including progress, barriers, and facilitators to implementation, data collection/entry/submission; Dissemination of progress report to stakeholders

Table 4. 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 CVD Evaluator. The CVD Evaluator will ensure technical assistance is provided to all individuals who collect data that feed into the 2304 cardiovascular health program performance measures. In addition, data will be presented to 2304 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 toward 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 focus on activities related

to community-clinical linkage and health systems change to reduce the burden of hypertension and high blood cholesterol 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 conferences, meetings, evaluation reports, the DPH website, and evaluation briefs. The 2304 team will present the evaluation findings to other 2304 states and local, state, and national level stakeholders through reports and conference calls.
Additional Narrative 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 the CVD program staff is currently working with. Proposed targets are comprised of health care systems the CVD team 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.

Appendix A:


Georgia Draft Logic Model Cardiovascular Disease Prevention Program
Outcomes
Inputs
Strategies
Outputs
Short-term: 0-1 year
Intermediate 2-3 years
3+ years
Funding
Staff
Collaborators – Health Systems, Pharmacies, CHWS
Community-based organizations
Evidence based Intervention guidelines
Track and Monitor Clinical and Social Services and Support Needs Measures Shown to Improve Health and Wellness, Health Care Quality, and Identify Patients at Highest Risk of Cardiovascular Disease (CVD) with a Focus on Hypertension and High Cholesterol.
Implement Team-Based Care to Prevent and Reduce CVD Risk with a Focus on Hypertension and High Cholesterol Prevention, Detection, Control, and Management through the Mitigation of Social Support Barriers to Improve Outcomes.
Link Community Resources and Clinical Services that Support Bidirectional Referrals, Self-Management, and Lifestyle Change to Address Social Determinants that Put the Priority Populations at Increased Risk for Cardiovascular Disease with a Focus on Hypertension and High Cholesterol.
# of FQHCs recruited and successfully engaged in the initiative.
% patient records in eClinical Works with relevant CVD measures.
# clinical measures tracked
# social services tracked
# CAT APULT Action plans
#clinical staff trained in QI
Level of participation in training
tools assessed
FQHCs using Findhelp.org
and type of referrals by CHW using FindHelp for social services
% increase in EHR or HIT adoption in the selected FQHCs.
LC assembled
and type of organizations in LC
Partnerships formed within LC
stakeholder agreements (MOUs) between LC members
Action plans developed by LC Factors (Barriers and Facilitators) affecting LC
of CHWs (or equivalent) who engage community organizations to support needs
# of patients participating in SMBP
# of adults with CVD referred to lifestyle change social support.
# of community-clinical links established
Increased use of EHRs/standard tools to improve detection of health care disparities and identify, track, monitor patients at highest risk of CVD
Increased EHRs use in care teams communication and coordination to monitor and address CVD patients needs
Increased multidisciplinary care teams using evidence-based guidelines to address social needs
Increased partnerships addressing identified barriers to social services need among CVD patients
Increased community-clinical linkages to identify and respond to social needs among CVD patients
Increase use of CHW/equivalent to provide continuum care addressing social needs
Increased use of SMBP with clinical support within populations at highest risk of hypertension
Improved blood pressure control among populations within partner health care and community settings
Reduced disparities in hypertension control among populations within partner health care and community settings
Increased utilization of social services and support among populations at highest risk of CVD, with a focus on hypertension and high cholesterol.
Decrease in the proportion of people with Cardiovascular Disease (Hypertension and High Cholesterol)
Increase in the number of people with access to multidisciplinary teams to manage cardiovascular disease.
Increase in the number of people with CVD whose social needs have been addressed.
Reduce the burden of CVD in Georgia
External factors, environmental influences or moderators:
Partnerships –New partnerships developed with social service providers, Pharmacies, Health Organizations.
Population of focus change in knowledge and behaviors