GEORGIA DEPARTMENT OF PUBLIC HEALTH

Cardiovascular Disease Prevention Program

2304 Logic Model

Inputs

Funding

Staff

Collaborators – Health Systems, Pharmacies, CHWS

Community-based organizations

Evidence based Intervention guidelines

Strategies

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.

Outputs

and % of clinics or health care systems that have EHR policies, protocols, and processes.
Percentage of patient records in eClinical Works with relevant CVD measures.
and % FQHCs recruited and actively participating in QI interventions
and % of FQHCs with CATAPULT plans components
of identified patients by characteristics

and % of clinics or health care systems that use EHR care team communication
adults multidisciplinary care teams for CVD
of pharmacies/ pharmacists offering CVD management/SMBP
# of CHWs trained on SMBP and deployed to community organizations.
# of extended teams- members trained to deliver CVD management
& type organization in CVD care teams
and type of services in CVD care teams
of meetings held, MOU/MOAs on CVD care

# of adults with CVD referred to lifestyle change social support.
# of community-clinical links established
# of CHWs (or equivalent) who engage community organizations to support needs
# of patients participating in SMBP

Outcomes

Short-term: 0 -1 year

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

Intermediate 2-3 years

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.

Long-Term 3+ years

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

<u>External factors, environmental influences or moderators</u>:
Partnerships –New partnerships developed with social service providers, Pharmacies, Health Organizations.
Population of focus change in knowledge and behaviors