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Diabetes Prevention and Management Program

Evaluation Plan for Fiscal Year 2025

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

GEORGIA DEPARTMENT OF PUBLIC HEALTH

A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes - CDC-RFA-DP-23-0020 Component A

Strategic Evaluation Plan for FY 2024

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Narrative of the Evaluation Approach

Strategies to evaluate:

- A.1 Strengthen self-care practices by improving access, appropriateness, and feasibility of diabetes self-management education and support (DSMES) services for priority populations
- A.3 Prevent diabetes complications for priority populations through early detection
- A.5 Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle change program (LCP) and the Medicare Diabetes Prevention Program (MDPP) by improving access, appropriateness, and feasibility of the programs

Evaluation Approach and Context:

The Georgia Department of Public Health (DPH) 2320 program will follow the Centers for Disease Control and Prevention's (CDC) Framework for Evaluation to conduct both process and outcome evaluations to determine the effectiveness and impact of program interventions. Georgia's 2320 program will address diabetes management and type 2 diabetes prevention by improving access of diabetes self-management education and support (DSMES) services for priority populations as well as National Diabetes Prevention Program (National DPP) lifestyle change program (LCP) services. Georgia activities aim to prevent complications of diabetes among its population through early detection. These strategic approaches will be implemented simultaneously in selected communities across the state.

Working with diverse local partners, the program targets populations at higher risk, focusing on those with undiagnosed or uncontrolled diabetes, especially in areas with disparities and inequalities. Three groups of stakeholders and partners will be involved at different levels in performance monitoring and evaluation of the program throughout the cooperative agreement. Key partners and program staff will be engaged in all phases of the evaluation process including planning, implementation, and use of evaluation results. In Year One, the primary stakeholders, GDPH Diabetes Program staff and program implementers, developed this evaluation plan. For the remainder of the cooperative agreement, the evaluation plan will be implemented where primary stakeholders including health districts and health systems will implement interventions, collect data, disseminate, and use evaluation data to improve interventions. Higher level stakeholders such as the statewide partners, national agencies and funders will disseminate and use evaluation and surveillance data to guide programming. List of partners/stakeholders, their role in the evaluation process and how and when they will be engaged are outlined in Table 3.

The overarching evaluation question Georgia will answer during this 5-year cooperative agreement period is "What progress has been made in Georgia to decrease diabetes burden and increase chronic disease awareness among the targeted populations?" Georgia will evaluate strategies 1, 3, and 5 while monitoring all other strategies the program is implementing (8, 9, and 12). The evaluation questions focus on the extent to which the program strategies and activities led to the expected outcomes. Evaluations will be carried out to determine the success of the program and make any adjustments necessary throughout the project period. 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 comprehensive evaluation

assessing approach, effectiveness, efficiency, and sustainability of the selected strategies throughout the project period will help inform the health impact for diabetes outcomes at the end of the cooperative agreement in year 5. Table 1 presents specific overarching evaluation questions for the core areas, evaluation design and data collection methods proposed for this project period. The specific evaluation questions and indicators for each strategy are detailed in Table 2: Strategy-Specific Evaluation Design and Data Collection.

Most of the data sources required to address the evaluation questions are readily available. Data 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. Performance measures, milestones, data sources, and assessment frequency are also described in Table 2. The sources include program records, activity data from meeting notes and data, and performance evaluation information To address those questions, both process and outcome evaluations will be conducted. Data will be collected and analyze using a mixed methods strategy, combining quantitative and qualitative methodologies.

The evaluation will combine both quantitative and qualitative methods. The proposed methods include the use of statistical analysis to assess key metrics such as Diabetes 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. Data from multiple data sources will be compiled, cleaned, coded, analyzed, and interpreted to provide a summary of findings. Monitoring data will 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.

Key evaluation efforts center on assessing the implemented strategies' contribution to measurable changes in the identified communities' health, behavior, and environment. Vital statistics data will be used to evaluate outcomes and health impact by year 5, stratified by demographics. 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.

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 2320 team will be responsible for presenting the evaluation findings to other 2320 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.

Table 1: Multi-Year Evaluation Design and Data Collection Matrix

Evaluation Core Areas	Overarching Core Area Evaluation Questions	Evaluation Design	Data Collection Methods
Approach	1. To what extent has Georgia's implementation approach resulted in achieving the desired outcomes?	A mixed-methods evaluation design approach would result in achieving the desired outcomes. This approach combines both quantitative and qualitative methods, allowing for a comprehensive assessment of the implementation process and its outcomes.	Quantitative Methods: • **Performance Monitoring:** Collecting data from Georgia's health management information systems (HMIS) and tracking Key Performance Indicators (KPIs). Qualitative Methods: • **Document Review**: Analysis of reports and other relevant documentation to understand the decision-making and adaptation processes during implementation.
Effectiveness	2.1 To what extent has Georgia increased the reach of program strategies to prevent and manage type 2 diabetes? 2.2 To what extent has implementing program strategies led to improved health outcomes among the identified priority population(s)? 2.3 What factors were associated with the effective implementation	The effectiveness of Georgia's program strategies in increasing reach will be assessed by evaluating the extent to which the targeted population (including high-risk groups) has access to and is utilizing diabetes prevention and management services. A mixed methods approach combining quantitative and qualitative methods will be employed to provide a comprehensive understanding of	**Quantitative Methods**: **Program Participation Data**: Collect data on the number and demographics of individuals participating in diabetes prevention and management programs (e.g., DPP, DSMES). **Health System Data**: Analyze data from healthcare providers to measure the uptake of diabetes prevention and management services, including screenings and referrals. **Geospatial Analysis**: Use GIS mapping to visualize the geographic distribution of program reach, identifying areas with high and low coverage. **Qualitative Methods**: **Focus Groups and Interviews**: Conduct with program participants, healthcare providers, and community leaders to understand the factors

	of program strategies?	the program's reach, health outcomes, and the factors contributing to its effectiveness.	influencing program reach and participation. **Community Assessments**: Engage with communities to assess local barriers and facilitators to accessing diabetes prevention and management programs.
Efficiency	3. To what extent has the NOFO affected efficiencies concerning infrastructure, management, partners, and financial resources?	The evaluation design will focus on assessing the efficiency of the program by evaluating how well resources were utilized in achieving the intended outcomes. It will focus on operational efficiency, including the timeliness of service delivery, coordination of activities, and resource utilization in reaching the targeted population. Mixed Methods will combine quantitative health data with qualitative insights from stakeholders to gain a comprehensive understanding of the efficiency of the program	**Quantitative Methods**: **Health Outcome Data:** • Use existing data sources (e.g., from HMIS or chronic disease registries) to calculate the number of people reached, diagnosed, or treated for type 2 diabetes as a direct result of the program. • Collect health outcome data (e.g., reductions in type 2 diabetes incidence, hospitalizations, management success) to measure the program's effectiveness in improving health outcomes. **Qualitative Methods**: • **Interviews with Key Stakeholders:** Interview key implementers at various levels (local and national) to gain insights into how efficiently resources were mobilized and managed during the program rollout. • **Document Review**: Review project management documents, and timelines to assess the efficiency of resource allocation and procurement processes. This will help determine if resources (e.g., supplies, equipment, and staff) were procured and utilized in a timely.
Sustainability	4. To what extent can the strategies	The evaluation design will focus on assessing the likelihood that the	**Quantitative Data Collection** • **Workforce Capacity Data:** Gather data on staffing levels and training: the number of trained healthcare

	implemented be sustained after the NOFO ends?	strategies and interventions implemented to prevent and manage type 2 diabetes in Georgia can be sustained beyond the funding period. **Capacity Assessment** evaluation will analyze the readiness and capacity of local institutions, healthcare providers, and stakeholders to continue implementing the strategies after the NOFO ends. The evaluation will employ Mixed Methods data collection methods.	providers, community health workers, and program staff who are capable of continuing program activities independently. Assess the sustainability of training programs and the ongoing availability of skilled personnel. • **Policy Integration Data**: Review health policies and strategic frameworks to identify whether the strategies implemented under the NOFO are now embedded in local or national health policies, indicating long-term sustainability. **Qualitative Data Collection** • Interviews with Program Managers and Healthcare Providers involved in the day-to-day implementation of the program to gather insights into their perception of the program's sustainability. This will explore resource availability, capacity-building efforts, and future plans for program continuity.
Impact	5. To what extent have the strategies contributed to a measurable change in health, behavior, or environment in a defined community, population, organization, or system?	The design will use a Mixed Methods Impact Evaluation approach, combining both Quantitative and Qualitative data collection and analysis methods. The goal is to assess the magnitude and nature of changes and identify how these changes can be attributed to the implemented strategies:	**Quantitative Data Collection** • **Secondary Data: Health Outcome Data** from health systems (e.g., hospital records, chronic disease registries) to track changes in key health indicators such as type 2 diabetes incidence, diabetes-related complications, and healthcare utilization (e.g., hospital admissions, outpatient visits) over time. • Collect data on the availability of diabetes prevention and management programs to assess access to services overtime. • Collect data on environmental factors that influence diabetes prevention and management, such

		Outcome Assessment	as access to healthcare services, community-based health programs, or the availability of healthy food options. • Use self-reported secondary data on behavioral changes, such as improvements in dietary habits, physical activity levels, medication adherence, and diabetes self-management practices. Main data source- BRFSS.

Table 2: Strategy-Specific Evaluation Design and Data Collection

1. Strategy-Specific Evaluation Approach and Context: The evaluation will utilize mixed-methods approach which combines quantitative and qualitative data to provide a comprehensive assessment of the program's effectiveness, sustainability, and impact. Key components of the evaluation approach will include: **Process Evaluation conducted in year 1 and 2** particularly focusing on how well access to DSMES services is being expanded to underserved populations. This can help identifying any barriers to participation or access, and monitoring referral pathways from healthcare providers. **Outcome Evaluation conducted in years 2, through 5** to assess the effects of DSMES services on participants' diabetes management behaviors (e.g., blood glucose monitoring, medication adherence) and clinical outcomes (e.g., HbA1c levels, emergency room visits). **Impact Evaluation conducted in years 3 through 5** will focus on long-term changes in health outcomes and healthcare utilization at the population level but particularly among high-risk and underserved populations, to determine the broader impact of improved DSMES services. **Sustainability Evaluation concudted in year 5** will assess whether the systems, partnerships, and resources established during the program can be maintained long-term. It will examine stakeholder involvement and the integration of DSMES into healthcare settings beyond the initial implementation period. The evaluation will be conducted in the context of addressing the high burden of diabetes in underserved communities in Georgia, where access to diabetes management resources is often limited. Evaluation findings will be regularly communicated to stakeholders for ongoing improvement and decision-making.
2. Strategy 1: Improve access, appropriateness, and feasibility of diabetes self-management education and support services.
3. Activities: Develop and disseminate culturally appropriate materials to expand programming and increase enrollment and retention of participants. **Activity 1.1:** Hispanic Health Coalition of Georgia (HHCGA) will develop and disseminate materials to increase enrollment and retention of Hispanic/Latino populations. **Activity 1.2:** Explore the development process for a diabetes dashboard to provide data on incidence and mortality for diabetes, high-risk chronic conditions and risk behaviors, screening, income, education, insurance status, and access to care. **Activity 1.3:** GAPHC will assist FQHCs in developing plans to expand programming into sites without active DSMES programs.

Activity 1.4: Implement action plans developed by 4 health districts to provide DSMES or diabetes support programs within selected counties in the health districts by adopting best practices for enrolling and tailoring services to priority populations, integrating assessments of social determinants of health, and creating referral processes.. **Activity 1.5:** Conduct survey of 15 UGA extension sites and utilize results to identify two high-priority areas to expand DSMES and diabetes support programming delivered by UGA extension sites. **Activity 1.6:** Facilitate two (2) regional meetings to ensure regional collaboration with Health Districts, FQHCs, and Community Partners to discuss best strategies and best practices, aimed to lead to systems change to increase referrals and enrollment of priority populations into diabetes management-focused programs.						
4. Evaluation Question	**5. Indicator/ Performance Measure**	**6. Data Source**	**7. Data Collection Methods**	**8. Data Collection Frequency**	**9. Data Analysis**	**10. Responsibility**
Overarching evaluation question: To what extent has Georgia increased access to and strengthened self-care programs to prevent and control diabetes?						
Approach: To what extent has Georgia's efforts increased access and availability of accredited DSMES services, and diabetes support programs?	• Number of new ADA-recognized, ADCES-accredited DSMES services, and diabetes support programs • Number of existing ADA-recognized, ADCES-accredited	ADCES/ADA, Program Records Quarterly Reports Program Records/Administrative Data Key informant interviews with program staff, healthcare providers, and organization leaders to assess	Program document reviews Interviews	Quarterly from program reports. Data will be reported annually to CDC	Quantitative and Qualitative methods to include: • Descriptive Analysis, frequency to summarize quantitative data on service	Evaluator and Program Manager

Effectiveness: To what extent have efforts to improve access, appropriateness, and feasibility of DSMES services led to increased utilization and participant satisfaction among diverse populations, particularly those from underserved or high-risk groups? **Efficiency:** How effective have the improved DSMES services been in enhancing participants' diabetes self-management behaviors, such as	DSMES services, and diabetes support programs • Number of new diabetes support programs or services established • Number of existing ADA-recognized or ADCES-accredited DSMES services and diabetes support programs that have tailored their programs or recruitment strategies to increase participation of priority populations • Number of people with diabetes with at least one encounter at an ADA	feasibility and sustainability of support services implemented.			availability, utilization, and participant demographics. • Thematic analysis of program reports and data to identify key themes related to access barriers • Map the geographic distribution of DSMES service delivery sites and participant locations to assess whether services are reaching	

blood glucose monitoring, medication adherence, and lifestyle changes, and in reducing diabetes-related health outcomes (e.g., HbA1c levels, emergency room visits)? **Sustainability:** What systems, partnerships, and resources have been established to ensure the long-term availability and integration of DSMES services within healthcare settings? **Impact:** What measurabl	recognized / ADCES accredited DSMES services • Number of people with diabetes (total number and number from priority populations) participating in diabetes support programs/ services • Number and percentage of referred individuals enrolling in DSMES programs. • Level of tailoring of DSMES curriculum to the specific needs of diverse populations (e.g., language adaptation, culturally sensitive content).				underserved or high-risk areas. • Track referrals, enrollment, and participation rates in DSMES services. • Analyze pre- and post-intervention behavior and related health outcomes (e.g., changes in participants' diabetes-related behaviors (A1C monitoring, medication adherence),	

e changes in health outcomes, such as reduced diabetes-related complications, or decreased healthcare utilization, have occurred among participants as a result of increased access to and engagement with DSMES services?	• Geographic distribution and reach of DSMES services (proximity to high-risk populations). • Proportion of people with diabetes with A1C>9				changes in nutrition and physical activity) using paired t-tests or other appropriate statistical tests.	

1. Strategy-Specific Evaluation Approach and Context: The evaluation will utilize mixed-methods approach which combines quantitative and qualitative data to provide a comprehensive assessment of the program's effectiveness, sustainability, and impact. Key components of the evaluation approach will include: **Process Evaluation conducted in year 1 and** to assess whether the enhanced screening protocols are being integrated as plannedand *how* the screening programs were enhanced. **Outcome Evaluation conducted in years 2, through 5** will evaluate the short-term and intermediate outcomes of enhanced screening programs, such as increased participation in screening, early detection of diabetes complications, and subsequent patient management improvements. **Impact Evaluation conducted in years 3 through 5** will focus on long-term and measurable outcomes of the enhanced screening programs in preventing complications from diabetes. **Sustainability Evaluation concudted in year 5** will assess whether the systems, partnerships, and resources established during the program can be maintained long-term. It will assess the long-term viability and continuation of the enhanced screening programs after initial implementation and funding.. The evaluation the evaluation will provide insights into the effectiveness of the enhanced screening programs in improving health outcomes and whether these programs can be maintained and expanded in the future.
Evaluation findings will be regularly communicated to stakeholders for ongoing improvement and decision-making. 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 2320 team will be responsible for presenting the evaluation findings to other 2320 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.

2. Strategy 3: Prevent diabetes complications for priority populations through early detection.

3. Activities:

Activity 3A.1a: Implement a CKD screening protocol with one health system to be incorporated into their current diabetes management protocol.

Activity 3A.2: Implement a Diabetic retinopathy screening protocol with one health to be incorporated into their current diabetes management protocol

Activity 3A.3: Train a Health System partners DSMES program facilitators on best practices for screening techniques for CKD and Diabetic Retinopathy.

Activity 3A.4: Partner with the National Kidney Foundation to provide technical assistance to one health system to utilize a CKD Change Package to establish and implement a population health quality improvement (QI) program to improve CKD diagnosis and management.

Activity 3A.5: Collaborate with DPH Injury Prevention Program to develop brain health messaging and education to share with partners implementing DSMES and diabetes support programming. Persons with diabetes enrolled in the programs would receive the education to learn prevention strategies for Alzheimer's and Related Dementia (ADRD).

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 2320 team will be responsible for presenting the evaluation findings to other 2320 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.

4. Evaluation Question	5. Indicator/ Performance Measure	6. Data Source	7. Data Collection Methods	8.Data Collection Frequency	9. Data Analysis	10. Responsibility
Overarching Evaluation Question: How effective have the early detection and intervention efforts in Georgia been at identifying and reducing diabetes-related complications among priority populations?						

Approach: What screening programs did Georgia enhance to prevent complications from diabetes? **Effectiveness:** How effectively were the planned screening protocols, training programs, and partnerships implemented across the health systems? **Efficiency:** To what extent did Georgia use available resources (time, staff, funding, and partnerships) to implement the screening protocols, training,	• Number of health care systems that integrate new or improved screening programs specifically targeting early detection of CKD, diabetic retinopathy, and neuropathy. • Number and percentage of patients with diabetes screened for diabetic retinopathy and chronic kidney disease (CKD) in health care organizations working with the recipient on this strategy • Number of healthcare professionals trained in the enhanced	Quantitative and Qualitative sources including: Program Records/Administrative Data Training records Health System Administrative data Patient Health Records Healthcare providers Surveys	Program document reviews Interviews with healthcare providers	Quarterly from program reports. Data will be reported annually to CDC	Quantitative and Qualitative methods: Descriptive Analysis - Analyze the number and types of screening programs enhanced, geographic coverage, and participation rates. **Trend analysis –** Compare data over time to assess increases in the number of screenings and early detection of diabetes complications **Geospatial analysis -** Map the distribution of enhanced screening programs across different regions in Georgia to assess accessibility. **Qualitative content analysis** Analyze interview and	Evaluator and Program Manager Healthcare Systems

and technical assistance programs to increase reach of the interventions within the health systems? **Sustainability:** To what extent have the health systems adopted and institutionalized the CKD and diabetic retinopathy screening protocols, training programs, and quality improvement initiatives, and what mechanisms are in place to ensure the continuation and scalability of these interventions beyond the initial	screening protocols. • Number of health systems reporting improved screening practices or detection rates after implementation of enhancements. • Number of messages developed to share with partners implementing DSMES and diabetes support programming. • Number of partners implementing DSMES and diabetes support programming • Proportion of people with diabetes with A1C >9.				survey data from healthcare providers to understand how the enhanced screening programs are being implemented and any challenges encountered.	

implementation phase? **Impact:** What measurable changes in early detection rates and management of CKD, diabetic retinopathy, and related complications have occurred as a result of the implementation of the screening protocols and training programs within the health system, particularly among priority populations?						

1. Strategy-Specific Evaluation Approach and Context: The evaluation will utilize mixed-methods approach which combines quantitative and qualitative data to provide a comprehensive assessment of the program's effectiveness, sustainability, and impact. Key components of the evaluation approach will include: **Process Evaluation conducted in year 1 and 2** particularly focusing on how well access to DSMES services is being expanded to underserved populations. This can help identifying any barriers to participation or access, and monitoring referral pathways from healthcare providers. **Outcome Evaluation conducted in years 2, through 5** to assess the effects of DSMES services on participants' diabetes management behaviors (e.g., blood glucose monitoring, medication adherence) and clinical outcomes (e.g., HbA1c levels, emergency room visits). **Impact Evaluation conducted in years 3 through 5** will focus on long-term changes in health outcomes and healthcare utilization at the population level but particularly among high-risk and underserved populations, to determine the broader impact of improved DSMES services. **Sustainability Evaluation conducted in year 5** will assess whether the systems, partnerships, and resources established during the program can be maintained long-term. It will examine stakeholder involvement and the integration of DSMES into healthcare settings beyond the initial implementation period. The evaluation will be conducted in the context of addressing the high burden of diabetes in underserved communities in Georgia, where access to diabetes management resources is often limited.

Evaluation findings will be regularly communicated to stakeholders for ongoing improvement and decision-making. 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 2320 team will be responsible for presenting the evaluation findings to other 2320 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.

2. Strategy 5: Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the Medicare Diabetes Prevention Program.

3. Activity(s):

Activity 5.1.A: National DPP programs will utilize the resource guide to enhance National DPP systems by adopting best practices for enrolling and tailoring services to priority populations, integrating assessments of social determinants of health, and creating referral processes.

Activity 5.2.A: The Hispanic Health Coalition of Georgia will develop and disseminate materials to increase enrollment and retention of Hispanic/Latino populations.

Activity 5.3.A: Explore the development process for a diabetes dashboard and utilize data from the Diabetes Dashboard to identify priority populations and analyze disparities in diabetes burden.

Activity 5.4.B: GAPHC and FQHCs will utilize resource guides to enhance and expand National DPP systems by adopting best practices for enrolling and tailoring services to priority populations, integrating assessments of social determinants of health, and creating referral processes.

Activity 5.5.B: Implement action plans developed by 4 health districts to provide National DPP within selected counties in the health districts by adopting best practices for enrolling and tailoring services to priority populations, integrating assessments of social determinants of health, and creating referral processes..

Activity 5.6.B: Conduct survey of 15 UGA extension sites and utilize results to identify two high-priority areas to expand National DPP delivered by UGA extension sites.

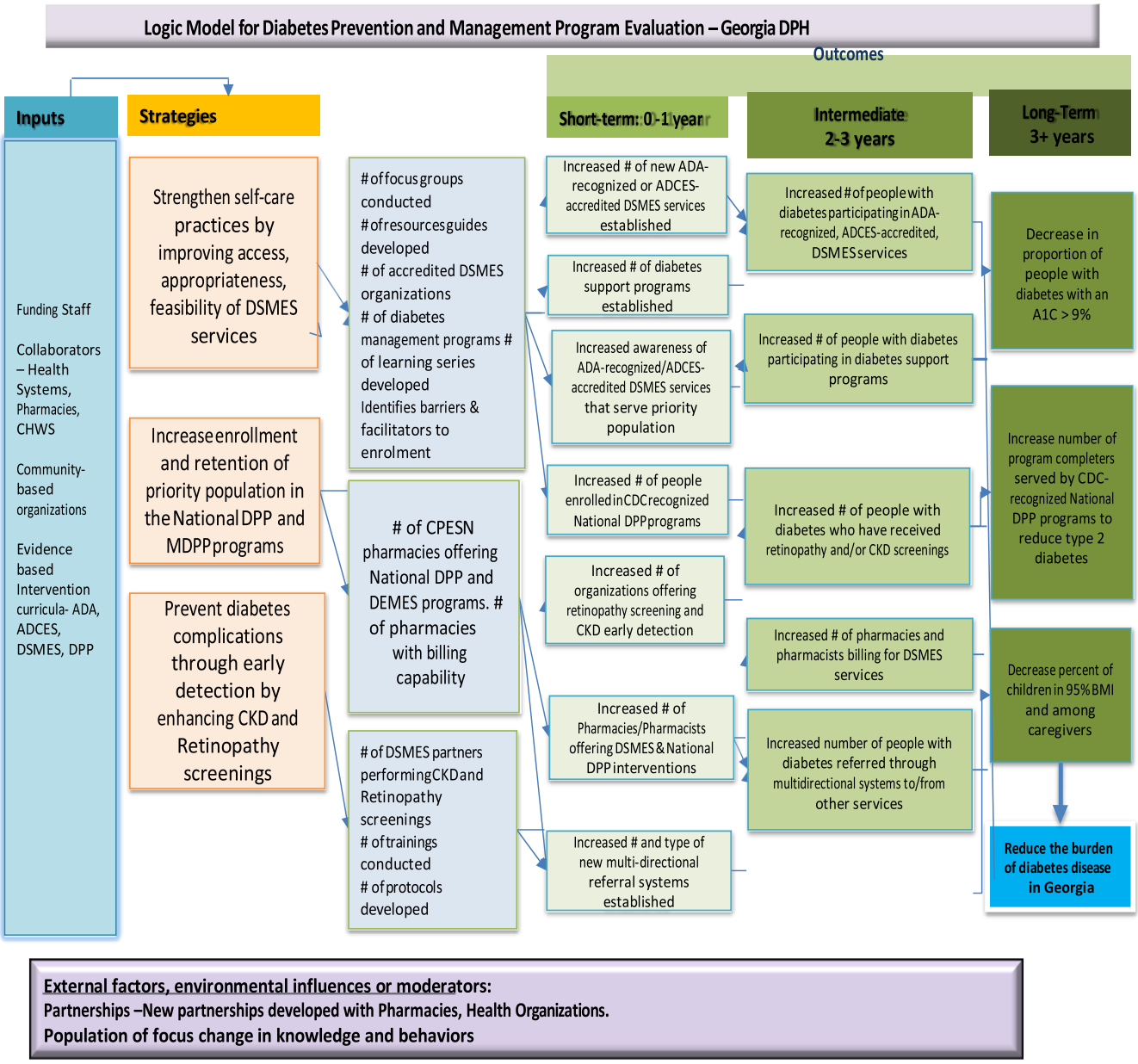
Activity 5.7.B: Facilitate two (2) regional meetings to ensure regional collaboration with Health Districts, FQHCs, and Community Partners to discuss best strategies and best practices, aimed to lead to systems change to increase referrals and enrollment of priority populations into National DPP and Medicare DPP. **Activity 5.8.B**: Implement the learning series to organizations currently offering National DPP to ensure systems are in place to aid in the progression to achieving MDPP Supplier status, increase the number of MDPP suppliers, and the number of referrals into the existing programs.						
4. Evaluation Question	**5. Indicator/ Performance Measure**	**6. Data Source**	**7. Data Collection Method**	**8. Frequency**	**9. Data Analysis Method**	**10. Responsibility**
Overarching evaluation question: To what extent has Georgia adopted and implemented the strategies and best practices outlined in the National DPP resource guides and action plans to improve enrollment and retention of populations affected diabetes and reduce disparities?						
Approach: What progress did Georgia make in enrolling and retaining participants in National DPP strategies? What priority populations were reached? **Effectiveness:** To what extent have the National DPP activities been effective in increasing enrollment, retention,	Number of National DPP programs that adopt the resource guide. Percentage of National DPP programs integrating assessments of social determinants of health. Number of referral processes established for priority populations. Number of materials developed and disseminated by the Hispanic Health Coalition. Number of participants (total # and # from priority populations)	Quantitative and Qualitative: National DPP program managers, resource guide usage reports, Dashboard analytics UGA extension site survey results Learning series attendance records	Quantitative Data: Enrollment/retention statistics, dashboard usage, supplier status records, survey responses. DPRP Reports Qualitative Data: Focus groups, key informant interviews, stakeholder feedback. Secondary Data: Diabetes prevalence reports, social determinants of health assessments, health district action plans.	Quarterly from program reports. Data will be reported annually to CDC	Quantitative and Qualitative including: Descriptive Statistics: To summarize and present data trends (adoption rates, enrollment numbers). Content Analysis: For qualitative data such as interview responses or focus group discussions. Geospatial Analysis: GIS mapping to identify high-priority areas and spatial disparities in service coverage.	Evaluator and Program Manager

and tailored services for priority populations? **Efficiency:** How efficiently have resources (e.g. partnerships, existing resource guides and plans) been utilized in implementing the National DPP activities, and what opportunities exist for optimizing processes to achieve desired outcomes? **Sustainability:** To what extent are the strategies, partnerships, and systems changes implemented through	enrolled by CDC-recognized National DPP delivery organizations Number of participants (total number and number from priority populations) retained* by CDC recognized National DPP delivery organizations. Number of program completers (total number and number from priority populations) served by CDC-recognized National DPP delivery organizations who reduce their risk for T2D. Number of actions or policy changes informed by the Diabetes Dashboard data. Number of FQHCs that adopt the resource guides.					

the National DPP in Georgia likely to continue after initial funding? **Impact:** What measurable impact have the National DPP activities had on reducing diabetes prevalence, improving health outcomes, and addressing disparities?	Percentage of FQHCs integrating assessments of social determinants of health into their practices. Number of counties in which National DPP programs have been launched or expanded. Number of organizations participating in the learning series. Number of organizations progressing towards or achieving MDPP Supplier status. Increase in the number of MDPP suppliers. Increase in the number of referrals into existing MDPP programs					

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 Diabetes Evaluator. The Diabetes Evaluator will ensure technical assistance is provided to all individuals who collect data that feed into the 2320 cardiovascular health program performance measures. The integrity of data will be safeguarded through secure storage solutions and strict access controls, with audit trails to track modifications. Data analysis will address data irregularities, and external validations with benchmarks or peer reviews will confirm the data's reliability. In addition, data will be presented to 2320 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 diabetes in the state of Georgia through the promotion and use of evidence-based interventions (EBIs). Baseline data will be collected to provide a reference point for future comparisons. Regular data collection and analysis will be carried out to monitor ongoing progress and trends. Comparative analysis will be used to evaluate the effectiveness of the program by comparing current data against the baseline. Based on the performance data, program strategies may be adjusted to enhance effectiveness. Program evaluator will be documenting and communicating these successes with stakeholders for maintaining engagement and support.
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 2320 team will present the evaluation findings to other 2320 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 Diabetes program staff is currently working with. Proposed targets are comprised of health care systems the Diabetes 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.


Logic Model for Diabetes Prevention and Management Program Evaluation – Georgia DPH
Outcomes
Inputs
Strategies
Short-term: 0-1 year
Intermediate 2-3 years
Long-Term 3+ years
Funding Staff
Collaborators – Health Systems, Pharmacies, CHWS
Community-based organizations
Evidence based Intervention curricula- ADA, ADCES, DSMES, DPP
Strengthen self-care practices by improving access, appropriateness, feasibility of DSMES services
Increase enrollment and retention of priority population in the National DPP and MDPP programs
Prevent diabetes complications through early detection by enhancing CKD and Retinopathy screenings
# of focus groups conducted
# of resources guides developed
# of accredited DSMES organizations
# of diabetes management programs # of learning series developed
Identifies barriers & facilitators to enrolment
# of CPESN pharmacies offering National DPP and DEMES programs. # of pharmacies with billing capability
# of DSMES partners performing CKD and Retinopathy screenings
# of trainings conducted
# of protocols developed
Increased # of new ADA-recognized or ADCES-accredited DSMES services established
Increased # of diabetes support programs established
Increased awareness of ADA-recognized/ADCES-accredited DSMES services that serve priority population
Increased # of people enrolled in CDC recognized National DPP programs
Increased # of organizations offering retinopathy screening and CKD early detection
Increased # of Pharmacies/Pharmacists offering DSMES & National DPP interventions
Increased # and type of new multi-directional referral systems established
Increased # of people with diabetes participating in ADA-recognized, ADCES-accredited, DSMES services
Increased # of people with diabetes participating in diabetes support programs
Increased # of people with diabetes who have received retinopathy and/or CKD screenings
Increased # of pharmacies and pharmacists billing for DSMES services
Increased number of people with diabetes referred through multidirectional systems to/from other services
Decrease in proportion of people with diabetes with an A1C > 9%
Increase number of program completers served by CDC-recognized National DPP programs to reduce type 2 diabetes
Decrease percent of children in 95% BMI and among caregivers
Reduce the burden of diabetes disease in Georgia
External factors, environmental influences or moderators:
Partnerships –New partnerships developed with Pharmacies, Health Organizations.
Population of focus change in knowledge and behaviors