Direct Services
Preventing and Managing Chronic Diseases

Notification of Funding Availability (NOFA)

DEADLINE: AUGUST 9, 2019 @ 3:00 PM EST

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Healthcare Georgia Foundation was created in 1999 as a statewide, charitable organization. Since inception, the Foundation has awarded 999 grants totaling $71.7 million to advance the health and well-being of Georgians. In 2018, the Foundation reviewed its mission, examined its strengths and conducted a scan of the ever-changing health and healthcare environment to develop a five-year Strategic Plan. Our blueprint for 2019-2023 is grounded in science, built on partnerships, and focused on results and reaffirms our vision, mission and values.

The Foundation’s vision is health equity in Georgia – where all people attain their fullest potential for health and well-being and our mission is to enable, improve, and advance the health and well-being of all Georgians. Future investments will be designed to achieve results for Georgians through strategic grantmaking and direct charitable activities among four program impact areas: 1) Addressing Health Disparities; 2) Expanding Access to Affordable, High Quality and Integrated Health Services; 3) Promoting Health and Preventing Disease; and 4) Strengthening Health Nonprofit Organizations, Programs, and Workforce. Over the next five years, the Foundation’s resources will be directed to six core priorities, including the Direct Services Grant Program, which will focus on preventing and managing chronic diseases. Click here for more information about the Foundation’s program impact areas and core program priorities.

In accordance with the Foundation’s five-year strategic plan and our vision of achieving health equity for all, the 2019 Direct Services Grant Program Notification of Funding Availability (NOFA) will align with the Foundation’s Promoting Health and Preventing Disease program impact area. Eligible organizations for the Direct Services Grant Program include nonprofit organizations, quasi-governmental organizations, and public health districts in Georgia that target vulnerable populations, including low-income, minority, rural and/or underserved individuals and communities. For a full list of eligibility criteria, please visit pages 13-14 of the NOFA.

Health promotion is the process of enabling individuals and communities to increase control over their own health. Health promotion embraces actions directed at strengthening the skills and capabilities of individuals, and includes strategies directed at changing the social, environmental, and economic conditions that contribute to the root causes of ill health among individuals and populations. Disease prevention refers not only to preventing the occurrence of disease (e.g.

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reducing risk factors), but also to slowing the progression and reducing the consequences of disease. Primary prevention is directed at preventing the initial occurrence of a disorder; secondary and tertiary preventions seek to manage or slow the progression of an existing disease and its effects through early detection, appropriate treatment, or rehabilitation.²

The Foundation has selected three high-burden costly chronic diseases that have proven evidence-based interventions and will award grants that utilize a best practice, promising approach, or evidence-based program that address:

- Asthma
- Cardiovascular disease, with an emphasis on heart disease and stroke
- Diabetes

The purpose of the 2019 Direct Services Grant Program is to promote health and well-being and to prevent and manage chronic diseases (asthma, cardiovascular disease and diabetes) across the lifespan of all Georgians with attention to vulnerable populations.

The Foundation is seeking programs/interventions that are evidence-based, best practices, or promising approaches that will make a lasting impact on the health of the defined target population.

**DIRECT SERVICES DEFINED**

Direct Services can be described as the implementation of a program or service(s) carried out to improve health outcomes among vulnerable populations and to ensure individuals have equitable access to high quality healthcare, resources, and community support in order to promote health and prevent and manage chronic diseases.

The 2019 Direct Services Grant Program supports new or existing evidence-based, promising approaches or best practice healthcare services or health promotion programs in both community and clinical settings. Expansion of existing healthcare services or health promotion programs based on effective interventions is also allowable. If requesting funds for a new program or expanding an existing program, the applicant must clearly demonstrate the ability to support and sustain the program beyond the requested funding from the Foundation.

Georgians should be able to live, work, learn, play and pray in environments where they can engage in healthy behaviors and access quality healthcare. Yet within many Georgia communities, there are social, cultural, and environmental conditions that impact residents’ health. Creating healthy environments for all Georgians requires active involvement by all segments of the community, including persons most affected by inequities, health providers, schools, government, businesses, and faith-based organizations.

Although health disparities are more commonly viewed through the lens of race and ethnicity, they occur across many dimensions, including socioeconomic status, age, location, gender, disability status, and sexual orientation. The health of Georgians is influenced not only by an individual’s knowledge of health risks, access to quality healthcare, and personal health behaviors; but also, the physical environment where people live, the jobs they hold, and the income they receive. Data show that a person’s physical environment as well as social and economic factors (e.g. education, employment, income) contribute just as equally to health outcomes (50%) as healthy behaviors and access to clinical care (50%).

Profound disparities in health may start prior to birth, extend through adolescence, continue into adulthood and contribute significantly to an individual’s ability to attain their fullest potential for health.

In accordance with our vision, Healthcare Georgia Foundation seeks to achieve greater health equity for all Georgians and utilizes the following key definitions as underlying themes to our work.

- **Health Equity**: where all people attain their fullest potential for health and well-being.
- **Health Disparity**: a particular type of health difference that is closely linked with social, demographic, economic, and/or environmental disadvantages.
- **Social Determinants of Health (SDOH)**: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.

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**Figure 1** (below) illustrates the socioeconomic and environmental, behavioral, and biological risk factors that can impact the selected Direct Services chronic disease focus areas (asthma, cardiovascular disease, and diabetes).

Through this NOFA, the Foundation invites submissions for projects that address at least one of the identified chronic diseases and uses a best practice, promising approach, or evidence-based intervention that will address biological, behavioral and socio-economic risk factors associated with the disease.

**FIGURE 1: FACTORS THAT IMPACT DIRECT SERVICES CHRONIC DISEASE FOCUS AREAS**

All applicants are required to identify how both the organization and proposed program addresses equity. Using an equity lens, you should consider the “root causes” or systemic barriers that impact the health of your target population. For example, addressing equity can include any combination of the following:

1. Focusing services based on the results of disaggregated data that determines the populations most affected by health disparities;
2. Recruiting and training staff to advance health equity;
3. Describing how populations most affected by health disparities are incorporated in the program design, implementation, and evaluation;
4. Describing how your organization addresses any of the social determinants of health (e.g. poverty, education, unemployment, race/ethnicity and other systemic barriers that impact health); or
5. Describing how your organization establishes partnerships to ensure diverse perspectives and sectors are represented to promote health and prevent disease.
The Foundation has selected three chronic diseases – asthma, cardiovascular disease (heart disease and stroke), and diabetes - that will serve as the focus for the Direct Services Grant Program during the next five years. These chronic diseases represent high-burden and costly health conditions, have significant disparities in health outcomes, and have proven evidence-based interventions to improve health and control costs. Focusing on a select number of chronic diseases allows the Foundation to be more strategic in our approach and include success measures to assess our progress over the next five years.

All applicants are required to address at least one of the identified chronic diseases, implement an effective intervention (evidence-based, promising approach or best practice) with demonstrated impact, and conduct an evaluation of the program. The selected project may need to be adapted to fit the target populations’ needs and culture.

The identified chronic diseases can impact individuals in different ways across the lifespan. Eligible programs can target children, adults, families, communities and neighborhoods, and can include advocacy and policy activities as a strategy of a larger programmatic effort to address the social determinants or systemic barriers that impact the selected chronic disease(s).

The Foundation is seeking programs/interventions that are evidence-based, best practice or promising approaches and will make a lasting impact on the health of the defined target population. Projects that target high disparity populations and include technically sound methods for measuring change over time will have a competitive advantage over projects that have limited or sporadic contact with participants (e.g. health fairs, school presentations).
Asthma is a chronic inflammatory disease of the lungs and airways that causes recurrent episodes of wheezing, breathlessness, chest tightness, and coughing and is a significant public health issue in both the United States and Georgia. Although the exact cause of asthma is unknown and there is no cure, asthma can be treated with self-management education, effective medical treatment, adherence to prescribed medications, and by controlling environmental triggers. According to the Centers for Disease Control and Prevention, asthma affects an estimated 25.1 million people in the United States. Asthma places a significant economic burden in the United States and can lead to a reduction in quality of life. Researchers found that the costs of asthma to society totaled $81.9 billion in 2013, including costs incurred by absenteeism and mortality.

In 2014, the overall asthma prevalence among adult Georgians 18 years and older was 8.4% and 10.2% among children under age 18. Similar to national trends, the asthma prevalence among Georgians was higher among females (10.0%) than males (6.7%), and higher among boys (14.1%) than girls (5.6%) under age 18. The 2015 Georgia Asthma Burden Report identified several disparities in asthma emergency room (ER) visits and hospitalizations. Among Georgia children under age 18, an average of 27,000 asthma ER visits occurred annually costing $44.2 million in 2012. The rate of asthma ER visits and hospitalizations among children in Georgia was highest among boys, African-Americans, and children 0-4 years. Among Georgia adults 18 years and older, an average of 28,700 asthma-related ER visits occurred annually costing $68.1 million in 2012. The number of asthma-related ER visits among adults was highest among females and African-Americans, and the rate of asthma hospitalizations among adults was highest among African-Americans, women and people 65 years and older.

Proposed programs that address asthma should utilize effective interventions that are proven to demonstrate impact. For example, the National Asthma Education and Prevention Program (NAEPP) Guidelines are used as part of evidence-based clinical practice and medical management of asthma. The NAEPP guidelines were developed by an expert panel commissioned by the NAEPP Coordinating Committee, coordinated by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health.

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8 2016 Georgia Data Summary for Adult Asthma. Georgia Department of Public Health.
9 2016 Georgia Data Summary for Asthma in Children. Georgia Department of Public Health.
11 National Heart, Lung, and Blood Institute. Guidelines for the Diagnosis and Management of Asthma (EPR-3).
CARDIOVASCULAR DISEASE (HEART DISEASE AND STROKE)

Cardiovascular disease (CVD) includes all types of diseases that affect the heart and blood vessels, including ischemic heart disease (also known as coronary artery disease, coronary heart disease or coronary microvascular disease), peripheral arterial disease, stroke, congestive heart failure, hypertension, atherosclerosis, and other CVD (e.g. aortic aneurysm, aortic dissection and diseases of the arteries, arterioles, and capillaries). According to the American Heart Association, cardiovascular disease attributes to 1 in 3 deaths in the United States (nearly 836,546 deaths).\(^\text{12}\) CVD claims more lives than all forms of cancer and chronic lower respiratory disease combined. The direct and indirect costs of total cardiovascular diseases and stroke are estimated to total more than $329.7 billion. This includes costs due to health expenditures and loss of productivity.\(^\text{12}\)

CVD is the leading cause of death in Georgia, accounting for 29% of all deaths (21,831) in 2013.\(^\text{13}\) In 2013, Georgia’s death rate due to CVD was 6% higher than the national rate, of which most of these deaths were premature and preventable. Each year, 136,000 years of potential life lost occurs in Georgia due to CVD. In 2013, the cost of CVD in Georgia totaled $6.3 billion. The age-adjusted mortality rate due to CVD is higher among Black males in Georgia (344.1 per 100,000), followed by White males (274.3 per 100,000), Black females (246.5 per 100,000), and White females (185.8 per 100,000). In 2012, approximately 133,419 hospitalizations occurred among Georgia residents due to CVD. The average length of hospital stay in Georgia was five days and the average charge per CVD-related hospitalization was $45,744.

Because most of the CVD deaths in Georgia were due to heart disease (16,430) and stroke (3,665), the Direct Services Grant Program will place a greater emphasis on programs that address heart disease and stroke. Proposed programs that address CVD should utilize effective interventions with demonstrated impact. For example, the Guide to Community Preventive Services (The Community Guide) provides a list of evidence-based strategies to address CVD, including implementing clinical decision-support systems at the point-of-care, incorporating team-based care to improve blood pressure control, and using interventions engaging community health workers.\(^\text{14}\)


\(^{13}\) Burden of Cardiovascular Disease in Georgia. Presentation to Chronic Disease University. Bayakly A., Director, Chronic Disease, Healthy Behaviors, and Injury Epidemiology Section. October 22, 2015.

DIABETES

Diabetes is a chronic disease that affects the pancreas’ ability to produce insulin, which regulates the levels of glucose in the blood.\textsuperscript{15} When the amount of blood glucose levels in the body are high, it can cause damage to other parts of the body, including the eyes, heart, blood vessels, kidneys and nerves. Uncontrolled blood glucose levels can lead to complications such as blindness, kidney disease, slow healing wounds, and even death. There is no cure for diabetes, but it can be effectively managed with adherence to prescribed medications and proper monitoring of blood glucose levels, blood pressure, cholesterol, diet, physical activity, and quitting smoking. Diabetes is a serious public health issue in both the United States and in Georgia. In the U.S., 30.3 million people, or 9.4% of the population, have diabetes and 1 in 4 do not know they are diabetic.\textsuperscript{16} In 2014, a total of 7.2 million hospital discharges and 14.2 million emergency room visits were reported with diabetes as any listed diagnosis among U.S. adults 18 years and older. In 2012, the total direct and indirect estimated costs of diagnosed diabetes in the U.S. was estimated at $245 billion.

In Georgia, approximately 1.1 million people, or 13.9% of the adult population, have diabetes.\textsuperscript{17} Of these, an estimated 241,000 have the disease but are not aware of it. The cost burden of diabetes is significant. Medical expenses for diabetics are approximately 2.3 times higher than those who do not have diabetes. In 2017, the total direct medical expenses for diagnosed diabetes in Georgia was estimated at $10.8 billion, including indirect costs lost from lost productivity due to diabetes.\textsuperscript{13} In Georgia, the prevalence of diabetes is higher among Black, non-Hispanics (13.7%), compared to White (9.9%) and Hispanic (7.2%) individuals.\textsuperscript{15} Seniors aged 65 years and older were also more likely to be diagnosed with diabetes (23.0%) compared to other age ranges. Diabetes prevalence was also higher among adults with a household income of less than $15,000 (15.7%) and adults with less than a high school education (14.3%).\textsuperscript{15}

There are different types of diabetes, including: 1) Type 1 diabetes, also known as juvenile diabetes; 2) Type 2 diabetes, which is the most common form of diabetes affecting 90-95% of the diabetic population; 3) Gestational diabetes, a type of diabetes most commonly found among pregnant women; and 4) Prediabetes, a condition in which the body’s glucose levels are high, but have not yet reached the level of a diabetes diagnosis.\textsuperscript{15} Applicants will be allowed to submit applications addressing any of the different types of diabetes that target populations across the lifespan from children to senior adults. Proposed program that address diabetes should utilize effective interventions with demonstrated impact. For example, the Guide to Community Preventive Services (The Community Guide) provides a list of evidence-based strategies to address diabetes, including team-based care for patients with Type 2 diabetes, combined diet and physical activity promotion programs to prevent Type 2 diabetes among people at increased risk, and lifestyle interventions to reduce the risk for gestational diabetes.\textsuperscript{18}

\textsuperscript{15} 2015 Georgia Diabetes Report and Action Plan. Georgia Department of Public Health
The Foundation has prepared examples of potential eligible activities and short-term outcomes to help you as you prepare your Direct Services application to address the identified chronic disease (Attachment A). The list of eligible activities and short-term outcomes is not exhaustive nor is it meant to be prescriptive, but merely are provided as a guide as you develop your application. All applicants will be required to develop SMART outcomes for the proposal and logic model (Attachment B).

**Application Guidelines**

Applicants may apply for up to $50,000 for a 12-month grant period. The Foundation will review all applications to ensure that the proposed activities align with the Foundation’s mission and the Promoting Health and Preventing Disease impact area. **Priority consideration will be given to organizations that demonstrate that they have matching cash funds allocated toward the project to demonstrate sustainability of the project and outcomes.** The Foundation will utilize an external review committee to review the applications. The Foundation anticipates that approximately 10-12 grants will be awarded; however, the number and amount of grant awards will be based on the number of applications received and/or the availability of Foundation funds. The Foundation anticipates that this program will be very competitive and therefore, strongly encourages applicants to research costs associated with proposed activities and make an appropriate request based on need.

**Criteria for Consideration** (includes the following, but is not limited to):

- Proposal is technically sound and aligns with the Promoting Health and Preventing Disease impact area
- Intentionally target low-income, uninsured, underserved populations, high-risk metropolitan or rural communities, or populations most affect by health disparities
- Proposal addresses how diversity, equity and inclusion is incorporated into the program design, delivery and evaluation.
  * Does the applicant organization’s board and staff look like the community served?
  * Are there diverse perspectives represented?
  * How is the underserved or high disparity population engaged in the program development, delivery and evaluation?
  * How are you addressing the Social Determinants of Health?
  * What partners do you engage to help you accomplish your goals?
- Comprehensive case statement that: 1) defines the groups who have benefitted from the services provided, and 2) explains how they have benefitted in measurable terms
- Cites and demonstrates that an effective intervention (*evidence-based, best practice or promising approach*) will be implemented with the proposed program/service
- Demonstrates evidence of capacity to evaluate results and outcomes of the proposed program
- Proposed budget is reasonable, cost-efficient and consistent with the proposed activities

**Eligible Outcomes and Examples**

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<thead>
<tr>
<th>Outcome Example</th>
<th>Description</th>
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<tbody>
<tr>
<td>Outcome 1</td>
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<td>Outcome 2</td>
<td>Example 2</td>
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<td>Outcome 3</td>
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Healthcare Georgia Foundation  ■  2019 Direct Services Grant Program NOFA  ■  Issued June 25, 2019
Applicants must develop a brief case statement including the organization’s mission and evidence of the organization’s history of performance and effectiveness of preventing and managing chronic diseases, and investment in underserved communities and/or vulnerable populations. Applicants are required to describe the demographics of the clients and communities who have benefitted from the organization’s services and describe how recipients have benefitted in quantifiable terms. This should also include information on why the organization is uniquely qualified to implement this program based on previous performance and specific accomplishments attributed to the individual organization.

**CASE STATEMENT**

Applicants must develop a brief case statement including the organization’s mission and evidence of the organization’s history of performance and effectiveness of preventing and managing chronic diseases, and investment in underserved communities and/or vulnerable populations. Applicants are required to describe the demographics of the clients and communities who have benefitted from the organization’s services and describe how recipients have benefitted in quantifiable terms. This should also include information on why the organization is uniquely qualified to implement this program based on previous performance and specific accomplishments attributed to the individual organization.

**IMPLEMENTING EFFECTIVE INTERVENTIONS**

Applicants must demonstrate they are implementing effective interventions by outlining how key aspects of promising practices will be put into place as intended, but also tailored to meet local needs. Promising practices may have some practice-based evidence such as evaluation data, with a limited number of participants or a specific population. Applicants must cite and demonstrate through available existing research or evaluation data that the proposed program is at least a promising practice and show how they have carefully adapted this effective practice to be culturally appropriate and specific to the target population without changing the program key elements likely to make it effective.

Evidence-based and best practices interventions must demonstrate they have undergone either a rigorous evaluation or a systematic review of available research or information indicating that the intervention/program results in the desired outcome. Despite evidence indicating their effects, these practices are not always effective in new or different situations. For example, increasing access to health services by lengthening clinic hours may not improve outcomes if language issues are the actual barriers. There may not be proven “program packages” that fit across all populations, settings and situations. Applicants will need to identify the current barriers to preventing and managing chronic diseases.

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19 Kansas University Community Tool Box. Retrieved May 31, 2018
diseases in their community and adapt effective practices to fit their target populations’ needs and culture.

For examples of best practices and evidence-based programs, view the links below:

- Kansas University Community Tool Box: [http://bit.ly/1S8Gn2i](http://bit.ly/1S8Gn2i)

**EVALUATION**

The Evaluation Resource Center (ERC) is Healthcare Georgia Foundation-directed and funded, and offers evaluation tools and services designed to help nonprofit health organizations achieve better outcomes. Please use the ERC’s free website and evaluation toolkit for assistance with the grant application at [www.georgiaerc.org](http://www.georgiaerc.org).

- **DIRECT SERVICES PRE-AWARD ON DEMAND EVALUATION WEBINAR.** The Foundation offers a Direct Services Pre-award Evaluation webinar to applicants and strongly encourages potential applicants to utilize this service. The pre-recorded on demand webinar covers how to develop a logic model and evaluation plan with SMART outcomes ([Attachment B](#)). This webinar is intended to simplify the evaluation process and strengthen your proposal.

- **REQUIRED LOGIC MODEL AND EVALUATION PLAN.** Effective evaluation begins with describing your program – what you are doing and why. Applicants are required to develop and submit a logic model and evaluation plan for the proposed program. Applicants can use the logic model to create a description of the proposed program, including resources needed, activities and direct products of the program, participants, and intended short-term outcomes. Completing the evaluation plan will help you decide what to focus on, what specific questions your evaluation will answer, and what practical and realistic information you need to answer those questions. Please use the logic model and evaluation plan templates provided with the application materials when developing your own program logic model and evaluation plan. For your reference, [Attachments C and D](#) serve as an example of a safety net clinic evaluating a diabetes management program.

- **REQUIRED 10% OF BUDGET TOWARDS EVALUATION.** Applicants are required to allocate a minimum of 10% of their proposed budget towards evaluation for this program. The Foundation recognizes that some health nonprofit organizations may choose to conduct evaluation activities on their own, while others prefer to partner with an external evaluator. This 10% can be used toward either allocating staff time for conducting evaluation activities or working with an external evaluator, or a combination of the two. It is required that you describe the identified evaluator’s experience in conducting evaluation and collecting, analyzing and reporting data for evaluation.
purposes. If needed, the ERC can provide you with a referral to an evaluator in your geographic or topical area.

- **PRE-AWARD EVALUATION COACHING CALLS.** During the application preparation phase, evaluation support is available to all applicants via the Foundation’s Evaluation Resource Center (ERC). Samantha Bourque Tucker, the Foundation’s Evaluation Manager, can provide assistance reviewing your case statement, logic model or putting together your evaluation plan. The Foundation strongly encourages potential applicants to view the Direct Services Pre-award On Demand Evaluation webinar before scheduling a coaching call. Applicants can schedule an appointment to receive an evaluation technical assistance call by filling out the following form by July 12th by 5:00 PM [https://tinyurl.com/DSCoachingCall](https://tinyurl.com/DSCoachingCall). Click here for tips on how to prepare for your pre-award evaluation coaching call.

- **REQUIRED POST-AWARD EVALUATION COACHING CALL.** All grant award recipients will be required to work with the ERC during the post-award phase to review the submitted logic model and evaluation plan, discuss baseline data, and prepare for submitting grantee progress reports.

### THE BASICS

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<thead>
<tr>
<th>MAXIMUM GRANT AMOUNT</th>
<th>$50,000</th>
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<tr>
<td>GRANT TERM</td>
<td>12 months</td>
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<td>GRANTS TO BE AWARDED</td>
<td>10-12</td>
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<tr>
<td>WHERE TO START</td>
<td>2019 Direct Services Pre-Application Webinar is strongly recommended July 10, 2019 @ 10 am EST</td>
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<tr>
<td>WHEN TO APPLY</td>
<td>Submit a complete online grant application and required attachments by August 9, 2019 @ 3 pm EST</td>
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<td>WHERE TO APPLY</td>
<td>Online Application Form</td>
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<td>HOW TO APPLY</td>
<td>Online Application Instructions</td>
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ELIGIBILITY CRITERIA

Who Should Apply

- Nonprofit organizations, including nonprofit hospitals, that are exempt from Federal income tax under provisions of Section 501(c)(3) of the IRS Code and defined as “not a private foundation” under Section 509(a).
- Quasi-governmental agencies
- Public health districts (limit 1 application per public health district)
- Organizations located in Georgia with programs targeting Georgia residents
- Previously funded organizations must be in good standing with the Foundation. Staff will determine whether previous grantees sufficiently complied with grantee requirements
- Given the Foundation’s commitment to vulnerable populations, the Foundation encourages diversity, representation, and inclusivity in the boards, staff and individuals served by the organizations we fund. This principle is shaped by the conviction that all segments of society benefit from diversity and equal opportunity.
What We Fund

Direct program costs can include expenditures on activities related to the functions of the program, including:

- Salaries/benefits for existing or new staff for program-specific activities. If you are proposing to hire new staff, you must include how you plan to sustain the position after the Foundation’s grant ends. Additionally, if you are creating a new position, attach a copy of the job description(s)
- Program-related equipment (e.g. laptop/desktop computers, iPads and printers) **(maximum of 10% of total grant request)**
- Other direct expenses (staff training, meetings/convenings, printing, etc.)
- Consulting fees
- Evaluation **(minimum of at least 10% of the total grant request)**
- Grant-related travel *if the applicant organization is located outside the metropolitan Atlanta region, please allocate resources to attend the Foundation’s Connections 2020 conference in Atlanta on March 30-31, 2020*
- Indirect expenses **(maximum of 10% of total direct costs)**

What We Do NOT Fund

- Colleges/universities, for profit organizations and governmental agencies (excluding public health districts) are ineligible to apply as the lead applicant. This includes College/University Foundations, Institutes, academic centers, and other entities affiliated with a college/university and/or governmental agency.
- More than one application per organization or department.
- Active grantees with the Foundation, including *EmpowerHealth* capacity building grantees and the lead organization participating in *The Two Georgias Initiative*. If you are a current grantee and have a question about eligibility, please contact your program officer.
- Funding that **primarily** supports client treatment/therapeutic regimens, pharmaceutical expenses, rehabilitation services, food distribution, transportation, housing or occupational services.
- Feasibility studies or needs assessments
- Capital campaigns or renovations
- Purchases of large equipment (see equipment restrictions)
- Basic biomedical research
- Grants or scholarships to individuals
- Event sponsorships
- Existing deficits or retroactive funding
- Activities that exclusively benefit the members of sectarian or religious organizations
<table>
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<tr>
<th>Date</th>
<th>Event Description</th>
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<tr>
<td>June 25, 2019</td>
<td>Online application launch for Direct Services Grant Program</td>
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<tr>
<td>July 10, 2019</td>
<td><strong>2019 Direct Services Grant Program Pre-application</strong> webinar at <strong>10:00 AM EST</strong>. Please use the following link to register for the webinar. The Foundation <strong>strongly encourages</strong> potential applicants to participate in this event. The webinar will cover the goals of this funding opportunity, provide information on evaluation expectations and address applicant questions. The webinar will be recorded and available on the Foundation’s website at the conclusion of the event. <a href="#">Register Here.</a></td>
</tr>
<tr>
<td>July 10, 2019</td>
<td><strong>Direct Services Pre-award On Demand Evaluation</strong> webinar posted to the Foundation’s website for applicants to view. The Foundation <strong>strongly encourages</strong> potential applicants to view this webinar.</td>
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<tr>
<td>July 12 - August 7, 2019</td>
<td><strong>Pre-award Evaluation coaching calls</strong> for the evaluation plan, logic model and case statement technical assistance available through the Evaluation Resource Center. Schedule an appointment by <strong>July 12, 2019 at 5:00 PM EST.</strong></td>
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<td>August 9, 2019</td>
<td>Online application and required attachments due by <strong>3:00 PM EST</strong></td>
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<td>August-October 2019</td>
<td>Internal and External Application Review</td>
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<td>December 2019</td>
<td>All applicants will be notified of the Foundation’s funding decision in writing.</td>
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<tr>
<td>December 12, 2019</td>
<td><strong>Required</strong> Grantee Orientation at <strong>10:00 AM EST</strong></td>
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<tr>
<td>January 1, 2020</td>
<td>Grant period begins</td>
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**Post Award** – All grantees will be assigned a Foundation staff member who will manage the grant and will be required to participate in an evaluation coaching call with the Foundation’s Evaluation Manager. Grantees will also have to submit a narrative and financial progress and final report every six months. Foundation staff ensures that grantees adhere to reporting and budget timelines.

The Foundation will host a grantee orientation webinar on **December 12, 2019 at 10:00 AM EST** for all organizations that are awarded. During the grantee orientation, the Foundation staff will provide guidance on executing the grant agreement and provide information on reporting and budget requirements and timelines. Following the grant awards, and after the grant agreements are fully executed, the Foundation will publicize and acknowledge the award through a media release.
ELIGIBILITY

Q: Who is eligible to apply?
A: The applicant organization should be tax exempt under section 501(c)(3) of the Internal Revenue Code and defined as “not a private foundation” under Section 509(a). Nonprofit hospitals, quasi-governmental agencies, and public health districts in Georgia are also eligible to apply. Please note, only 1 application per public health district will be accepted. Refer to pages 13-14 of the NOFA for eligibility criteria.

Q: Beyond the eligibility criteria of the Direct Services Grant Program, what are your general funding guidelines?
A: You can find our general funding guidelines at https://www.healthcaregeorgia.org/frequently-asked-questions/.

Q: Can my project address more than 1 of the identified chronic diseases (asthma, CVD, diabetes)?
A: Yes, your project can address more than 1 of the identified chronic diseases, particularly regarding populations that may have both diabetes and a cardiovascular disease(s).

Q: Can I submit more than one application?
A: The Foundation will only accept one application per organization.

Q: What is a quasi-governmental entity?
A: Quasi-governmental entities are supported by the government, but managed privately. A community mental service board is an example of a quasi-governmental organization.

Q: Are public health districts/departments eligible to apply?
A: Yes, any of the 18 public health districts in Georgia will be eligible to apply for the 2019 Direct Services Grant Program. However, only 1 application per public health district will be accepted. For example, if your district covers 16 counties, you will only be allowed to submit 1 application from the district.

Q: What if our organization is a nonprofit foundation for a university/college - are we eligible to apply?
A: No, a foundation will not be permitted to apply on behalf of an organization that would otherwise be deemed as ineligible to apply on its own.
Q: My organization has a current grant with Healthcare Georgia Foundation, can we apply?
A: If your organization has an active grant with the Foundation, you are not eligible to apply. If you are unsure whether your grant is active, please contact your assigned program officer.

Q: I am a previous Foundation grantee, but am not sure if my organization is in good standing.
A: Please contact the Foundation and ask for your program officer.

Q: My organization received an award for the Foundation’s Two Georgias Initiative. Can I also apply for Direct Services?
A: If your organization is funded as the lead organization applying for the Foundation’s Two Georgias Initiative, you are not eligible to apply for Direct Services. Partner organizations not serving as the lead organization for The Two Georgias Initiative are eligible to apply, if they meet the eligibility criteria defined on pages 13-14 of the NOFA.

Q: I applied for the Direct Services Grant Program last year, but was not awarded a grant. Is my organization eligible to apply?
A: If you applied to the Direct Services Grant Program last year and do not know why your application was declined, please contact Andrea Young Kellum, Senior Program Officer, at akellum@healthcaregeorgia.org or 404-653-0990. If your organization was deemed eligible to apply for Direct Services, you are eligible to reapply if you meet the general eligibility criteria listed on pages 13-14 of the NOFA.

FUNDING GUIDELINES AND REQUIREMENTS

Q: What is the dollar range of grant awards?
A: Organizations can apply for up to $50,000 for a 12-month period.

Q: How many grants will you award?
A: The Foundation anticipates awarding approximately 10-12 grants, however the number and amount of grants awarded will depend on the number of grants received and the availability of funds (see NOFA page 9).

Q: Are matching cash grants/funds required at the time of the Direct Services application submission?
A: No, matching cash grants/funds are not required to apply for the Direct Services Grant Program. However, to ensure the sustainability of the project and outcomes, matching funds are encouraged. You can demonstrate any matching funds you have in the Funder List Template and in the “Other Funding Sources” column in the Direct Services Budget Template.

Q: What are indirect costs?
A: These are overhead expenses that relate to the overall operations of an organization or are shared
among projects or functions. Examples of indirect costs include accounting, insurance, legal services, utilities, rent and facilities. The Foundation will support up to 10% of the requested total direct costs for indirect expenses.

Q: What are direct costs?
A: Direct costs are listed in the Direct Services Budget Template as operating costs and can include salaries/fringe benefits, supplies, printing/copying, telephone & fax, travel, staff and board development, and postage & delivery.

Q: Do you have any financial limits to grant requests?
A: Generally, the Foundation recommends that you do not request more than 25% of your organization’s annual operating expense budget. Organizations that request greater than 25% of their operating budget may be declined without a full review.

Q: What if my organization does not conduct an audit?
A: Submit the most recent IRS Form 990 and attach a letter explaining why the organization does not conduct an audit. You may be asked to submit additional information during the application review period. All organizations that do not conduct audited financial statements are designated by the Foundation staff as high risk.

APPLICATION PROCESS

Q: How do I submit my application?
A: All applications must be submitted using the Foundation’s online application. You can use an email address to set up an account at https://www.grantrequest.com/SID_717/?SA=AM Once you have established an account, you can complete the application questions. You will be able to update your application until the deadline on August 9, 2019 at 3:00 PM. You must hit “Submit” to process your application. Once you click Submit, you will not be able to make changes to your application. You will receive an email confirmation that we received your application. To avoid delays or complications in submitting your application or uploading documents, we strongly advise that you do not wait until the last day to submit your completed application.

Q: How do I gain access to the application once I have started?
A: Use the following link once you have started and saved your Direct Services application. This will give you full access to your account. https://www.grantrequest.com/SID_717/?SA=AM

Q: If I am in the middle of my application, can I save and continue to work on it later?
A: Yes. Click the Save and Finish Later button located at the bottom of the page. This will save all your work. When you are ready to continue, click on the link emailed to you when you created your account.
Q: I have submitted a previous online application to the Foundation, but cannot remember my password.

A: Email or call Javier Sanchez, Grants Manager, at jsanchez@healthcaregeorgia.org or via phone at 404.653.0990.

Q: The person who created our online application account is no longer with our organization.

A: Email or call Javier Sanchez to transfer the account to a new email address.

Q: I need to make a correction/update to my application after I have submitted? What should I do?

A: If you have changes to your application after submission, but prior to the deadline, please contact Javier Sanchez. If the application deadline has already passed, you will be unable to correct/update your application.

Q: What happens after I submit my application?

A: You will receive an email confirmation. If you do not receive an email confirmation, check your junk or spam folders. If you still do not have the email confirmation, contact Javier Sanchez.

**FOUNDATION CONTACT INFORMATION**

**Grant Application:** General questions about the application, budget and attachment requirements should be addressed to:
- Andrea Young Kellum, Senior Program Officer, akellum@healthcaregeorgia.org

**Online Application Technical Assistance:** Questions about the online application and/or troubleshooting the application should be addressed to:
- Javier Sanchez, Grants Manager, jsanchez@healthcaregeorgia.org

**Evaluation or Logic Model:** Questions about the case statement, logic model, evaluation plan and developing SMART outcomes for your program should be addressed to:
- Samantha Bourque Tucker, Evaluation Manager, stucker@healthcaregeorgia.org

**Communications:** Questions about use of the Foundation’s logo or other communications guidelines should be addressed to:
- Andrea Berry, Director of Communications, aberry@healthcaregeorgia.org

**All Foundation staff may also be reached by phone at (404) 653-0990**

**INQUIRIES:** Please do not contact the Foundation to inquire about the status of an application that has already been submitted. The Foundation staff is not at liberty to disclose the status of an open application before a funding decision is reached.
### Asthma Example Activities
- Implement strategies that improve access and adherence to asthma medications and devices.
- Educate asthmatic children/adults on diet and exercise
- Educate asthmatics on healthy behaviors
- Educate asthmatic adults that their children are 3 to 6 times more likely to develop asthma (non-modifiable risk factor)
- Provide team-based care for patients with asthma
- Provide self-management education for people whose asthma is not well-controlled by licensed professionals or qualified lay health workers with the medical management approach outlined in the NAEPP Guidelines
- Conduct health promotion campaigns targeting specific populations focused on asthma
- Develop and maintain an asthma care action plan
- Educate healthcare providers on the NAEPP Guidelines as part of evidence-based clinical practice and medical management
- Provide cultural competency assessments, data collection, trainings, workshops, and/or webinars for healthcare providers/workforce
- Use of interpreter services or bilingual providers for clients with Limited English Proficiency
- Integrate care management between the home, healthcare providers, schools, and/or childcare settings
- Develop local policies and regulations to reduce exposure to asthma environmental triggers
- Expand access to home visits by licensed professionals or qualified lay health workers
- Implement strategies to address the social determinants of health

### Example Short-Term Outcomes
- Increase in adherence to prescribed medications and/or devices
- Increase in knowledge of healthy behaviors and comorbidities (i.e. obesity)
- Decrease consumption and exposure of tobacco products, including e-cigarettes
- Reduce behavioral risk factors among vulnerable populations
- Reduce the number of school and/or work days missed due to asthma
- Increase in number of adults who are aware their children are more susceptible and to pay attention to signs
- Increase the number of healthcare providers that utilize evidence-based programs and guidelines to diagnose, manage, and treat asthma
- Increase/change knowledge of disease management among children, caregivers, and/or adults
- Increase in number of asthma care action plans
- Decrease in number of days affected by asthma symptoms; decrease in ER or hospital visits
- Increase/change in provider/workforce knowledge of how to provide culturally competent care
- Increase access to care for clients with Limited English Proficiency
- Increase care management between healthcare providers and other community sectors
- Decrease exposure of environmental triggers for people with asthma
- Increase access to care for vulnerable populations
- Increase the number of leveraged partnerships with state, local and federal public health agencies to shape policy and programs that impact asthma
<table>
<thead>
<tr>
<th>Cardiovascular disease (heart disease and stroke) Example Activities</th>
<th>Example Short-Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Educate individuals on controllable CVD behavioral risk factors (i.e. unhealthy diet, physical inactivity, tobacco exposure or use)</td>
<td>• Increase in knowledge of healthy behaviors and comorbidities</td>
</tr>
<tr>
<td>• Implement strategies that address nutrition, physical activity, smoking for those with prehypertension and/or hypertension (who meet the recommended guidelines for BMI)</td>
<td>• Increase/change in behavior modification</td>
</tr>
<tr>
<td>• Implement strategies that improve access and adherence to CVD medications (i.e. anti-hypertensive and/or lipid-lowering prescription medications)</td>
<td>• Reduce behavioral risk factors among vulnerable populations</td>
</tr>
<tr>
<td>• Educate individuals on controllable (i.e. high blood pressure, high cholesterol, overweight/obesity) CVD biological risk factors</td>
<td>• Decrease the number of prehypertension and/or hypertension patients who meet recommended guidelines for BMI</td>
</tr>
<tr>
<td>• Implement strategies to improve blood pressure and/or lower cholesterol</td>
<td>• Increase in adherence to prescribed medications and/or devices</td>
</tr>
<tr>
<td>• Provide team-based care for patients with CVD</td>
<td>• Increase knowledge of healthy behaviors and comorbidities</td>
</tr>
<tr>
<td>• Provide self-management education and/or strategies on regularly checking blood pressure and/or cholesterol</td>
<td>• Increase/change knowledge of disease management among those at risk for CVD</td>
</tr>
<tr>
<td>• Educate individuals on CVD risk factors (i.e. smoking, lack of physical activity, being overweight or obese, high BP and/or cholesterol, poor diet and eating habits, and diabetes)</td>
<td>• Increase the number of individuals whose blood pressure and/or cholesterol is under control and within normal ranges</td>
</tr>
<tr>
<td>• Conduct health promotion campaigns targeting specific populations focused on CVD</td>
<td>• Increase the number of healthcare providers that utilize evidence-based programs and guidelines to diagnose, manage, and treat CVD</td>
</tr>
<tr>
<td>• Provide cultural competency assessments, data collection, trainings, workshops, and/or webinars for healthcare providers/workforce</td>
<td>• Increase knowledge of disease management among those at risk for CVD</td>
</tr>
<tr>
<td>• Use of interpreter services or bilingual providers for clients with Limited English Proficiency</td>
<td>• Increase knowledge of CVD risk factors among target population</td>
</tr>
<tr>
<td>• Educate patients on the symptoms of and how to respond to a heart attack and/or stroke</td>
<td>• Increase/change in provider/workforce knowledge of how to provide culturally competent care</td>
</tr>
<tr>
<td>• Integrate care management strategies</td>
<td>• Increase access to care for clients with Limited English Proficiency</td>
</tr>
<tr>
<td>• Increase care management between healthcare providers and other community sectors</td>
<td>• Increase/change in knowledge/skills/ability of individuals able to respond to a heart attack and/or stroke</td>
</tr>
<tr>
<td>• Expand access to home visits by licensed professionals or qualified lay health workers</td>
<td>• Decrease in hospital and/or ER visits for patients with CVD</td>
</tr>
<tr>
<td>• Implement strategies to address the social determinants of health</td>
<td>• Increase access to care for vulnerable populations</td>
</tr>
<tr>
<td>• Develop local policies and regulations that reduce associated CVD risk factors</td>
<td>• Increase the number of leveraged partnerships with state, local and federal public health agencies to shape policy and programs that impact CVD</td>
</tr>
<tr>
<td>Diabetes Example Activities</td>
<td>Example Short-Term Outcomes</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Educate individuals on controllable diabetes behavioral risk factors (i.e. unhealthy diet, physical inactivity, tobacco exposure or use)</td>
<td>• Reduce behavioral risk factors among vulnerable populations</td>
</tr>
<tr>
<td>• Implement strategies that improve access and adherence to diabetes medications and devices.</td>
<td>• Increase in knowledge of healthy behaviors and comorbidities</td>
</tr>
<tr>
<td>• Implement strategies to lower high blood glucose (HbA1C) levels</td>
<td>• Increase diabetes-related healthy behaviors (i.e. increased physical activity, healthy diet, annual eye exams, etc.)</td>
</tr>
<tr>
<td>• Provide team-based care for patients with diabetes</td>
<td>• Increase the number of individuals whose HbA1C levels are under control and within normal ranges</td>
</tr>
<tr>
<td>• Implement strategies to improve blood pressure among people with diabetes</td>
<td>• Increase the number of healthcare providers that utilize evidence-based programs and guidelines to diagnose, manage, and treat diabetes</td>
</tr>
<tr>
<td>• Provide self-management education and/or strategies on diabetes education programs for people with pre-diabetes and/or diabetes</td>
<td>• Increase the number of diabetics whose blood pressure is under control and within normal ranges</td>
</tr>
<tr>
<td>• Conduct health promotion campaigns targeting specific populations focused on diabetes</td>
<td>• Increase/change in knowledge and awareness of diabetes management</td>
</tr>
<tr>
<td>• Provide cultural competency assessments, data collection, trainings, workshops, and/or webinars for healthcare providers/workforce</td>
<td>• Increase/change in provider/workforce knowledge of how to provide culturally competent care</td>
</tr>
<tr>
<td>• Use of interpreter services or bilingual providers for clients with Limited English Proficiency</td>
<td>• Increase access to care for clients with Limited English Proficiency</td>
</tr>
<tr>
<td>• Integrate care management strategies</td>
<td>• Increase access to care referred to the appropriate diabetes management program</td>
</tr>
<tr>
<td>• Expand access to home visits by licensed professionals or qualified lay health workers</td>
<td>• Decrease in hospital and/or ER visits for diabetic related complications</td>
</tr>
<tr>
<td>• Implement strategies to address the social determinants of health</td>
<td>• Increase access to care for vulnerable populations</td>
</tr>
<tr>
<td>• Develop local policies and regulations that reduce associated diabetes risk factors</td>
<td>• Increase the number of leveraged partnerships with state, local and federal public health agencies to shape policy and programs that impact diabetes</td>
</tr>
</tbody>
</table>
SMART OUTCOMES

After you select a funding category and eligible activity (page 4), you will be asked to develop a program-related SMART outcome that you plan to achieve within the 12-month grant period, on your application. For each program-related SMART outcome, you will need to identify the indicators and data collection methods, in the evaluation plan, you will use to evaluate the progress of the outcome from baseline. Your program-related SMART outcomes in the application should be the same as your short-term outcomes listed in your logic model (Attachment B).

Developing SMART Outcomes

One way to develop well-written outcomes is to use the SMART approach. Developing specific, measurable outcomes requires time, orderly thinking, and a clear picture of the results expected from program activities. The more specific your outcomes are, the easier it will be to demonstrate success.

SMART stands for

Specific
Measurable
Attainable/Achievable
Relevant
Time Bound

Specific - What exactly are we going to do for whom? The “specific” part of an outcome tells us what will change for whom in concrete terms. It identifies the population or setting, and specific actions that will result. In some cases it is appropriate to indicate how the change will be implemented (e.g., through training). Coordinate, partner, support, facilitate, and enhance are not good verbs to use in outcomes because they are vague and difficult to measure. On the other hand, verbs such as provide, train, publish, increase, decrease, schedule or purchase indicate clearly what will be done.

Measurable - Is it quantifiable and can WE measure it? Measurable implies the ability to count or otherwise quantify an activity or its results. It also means that the source of and mechanism for collecting measurement data are identified, and that collection of these data is feasible for your program or partners.

A baseline measurement is required to document change (e.g., to measure percentage increase or decrease). If the baseline is unknown or will be measured as a first activity step, that is indicated in the outcome as, “baseline to be determined using XXX database, 20XX.” The data source you are using and the year the baseline was obtained is always specified in your outcome statement. If a specific measurement instrument is used, you might want to incorporate its use into the outcome.

Another important consideration is whether change can be measured in a meaningful and interpretable way given the accuracy of the measurement tool and method.

Attainable/Achievable - Can we get it done in the proposed time frame with the resources and support we have available? The outcome must be feasible with the available resources, appropriately limited in scope, and within the program’s control and influence.

Sometimes, specifying an expected level of change can be tricky. To help identify a target, talk with an epidemiologist, look at historical trends, read reports or articles published in the scientific or other literature, look
at national expectations for change, and look at programs with similar outcomes. Consult with partners or stakeholders about their experiences. Often, talking to others who have implemented similar programs or interventions can provide you with information about expected change.

In some situations, it is more important to consider the percentage of change as a number of people when discussing impact. Will the effort required to create the amount of change be a good use of your limited resources?

**Relevant** - Will this outcome have an effect on the desired goal or strategy? Relevant relates to the relationship between the outcome and the overall goals of the program or purpose of the intervention. Evidence of relevancy can come from a literature review, best practices, or your theory of change.

**Time Bound** - When will this outcome be accomplished? A specified and reasonable time frame is incorporated into the outcome statement. This takes into consideration the environment in which the change must be achieved, the scope of the change expected, and how it fits into the overall work plan. It may be indicated as, “By December 2010, the program will...” or, “Within six months of receiving the grant...”

**Using SMART Outcomes**

Writing SMART outcomes also helps you to think about and identify elements of the evaluation plan and measurement, namely indicators and performance measures. An indicator is what you will measure to obtain observable evidence of accomplishments, changes made, or progress achieved. Indicators describe the type of data you will need to answer your evaluation questions. A SMART outcome often tells you what you will measure.

A performance measure is the amount of change or progress achieved toward a specific goal or outcome. SMART outcomes can serve as your performance measures because they provide the specific information needed to identify expected results.

**Getting Started**

To develop SMART outcomes, use the template below and fill in the blanks:

By _____/_____/_____, __________________________________________________________
[WHEN—Time bound] [WHO/WHAT—Specific]

from _____________________ to __________________________________________
[MEASURE (number, rate, percentage of change and baseline)—Measurable]

Adapted from materials developed by the Institute of Medicine and Centers for Disease Control
Healthcare Georgia Foundation Safety Net Case Study Logic Model

**INPUTS**
The resources of **WHAT YOU HAVE** to carry out the program (i.e., time, expertise, funding, technology, partners, information)

**OUTPUTS**
**WHAT YOU DO**
(i.e., the specific activities you will undertake like meetings, press releases, training, direct services) and
**WHO WILL PARTICIPATE OR BE REACHED**
(i.e., for each activity, the people you are trying to reach)

**OUTCOMES**
**WHAT HAPPENS OR CHANGES** as a result of what you do
(i.e., what will be different in the short-term (e.g., 1 year), intermediate (e.g., 2-5 years), and long-terms (e.g., >5 years) if you are successful?)

*The short-term outcomes identified here should be consistent throughout the evaluation plan and grant proposal.*

### Activities
- Recruit and train 3 bilingual clinical volunteers (RN or NP) to co-facilitate meetings
- Schedule and staff bi-weekly Diabetes Management Program (DMP) group sessions
- Refer all diabetic patients to DMP meetings
- Track patient attendance
- Monitor meeting process
- Track DMP participants’ health outcomes via EMR

### Participation
- Diabetic patients and their families
- Clinical volunteers (co-facilitators)

### Short-term
- All patients newly diagnosed with diabetes are referred to the DMP
- 50% of diabetic patients referred to DMP meetings attend at least 3 sessions
- 90% of participants report satisfaction with the program
- 100% DMP participants report increased awareness of diabetes management issues and strategies
- 80% of participants who attended 3+ meetings report improved diabetes-related health behaviors (e.g., increased physical activity, healthy diet, adherence to medications, annual eye exams)

### Intermediate
- 50% of participants show improvement in at least 2 diabetes-related health status indicators (e.g., BMI, blood glucose, blood pressure)
- Increased ability of DMP participants to self-manage diabetes
- Lower hospital admissions and ER utilization rates among DMP participants

### Long-term
- Lower incidence of diabetes-related complications in DMP participants (e.g., cardiovascular disease, end stage renal disease, retinopathy, neuropathy)
- Lower long-term costs associated with diabetes care
Please complete the attached evaluation plan, based on your outcomes as submitted in your grant proposal and logic model.

<table>
<thead>
<tr>
<th>EVALUATION QUESTIONS</th>
<th>INDICATORS</th>
<th>DATA COLLECTION METHOD</th>
<th>TIMELINE &amp; PERSON(S) RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: is the program increasing student academic achievement?</td>
<td>a. Students’ increase in both math and language standardized test scores.</td>
<td>a. Standardized tests</td>
<td>a. Data collected in November by teachers, submitted to evaluator for analysis</td>
</tr>
<tr>
<td></td>
<td>b. Teachers report increased child participation in classroom and homework.</td>
<td>b. Interviews with teachers</td>
<td>b. Data collected bi-annually (fall &amp; spring) by evaluator</td>
</tr>
<tr>
<td>1. Are participants improving health behaviors to manage their diabetes?</td>
<td>a-d. Participants’ adherence to recommended diabetes-related health promotion behaviors (pre/post): dietary guidelines, exercise, blood glucose monitoring, and prescribed medication regimen</td>
<td>Patient survey</td>
<td>Data collected at 3, 6 and 12 months by the Program Coordinator</td>
</tr>
<tr>
<td>2. Has the health status of program participants improved as a result of the program?</td>
<td>a. Improvements in diabetes-related clinical outcomes (i.e., Blood pressure, HbA1c, LDL, BMI) (pre/post)</td>
<td>Document review of Clinic EMR</td>
<td>Data collected semi-annually by the Program Coordinator</td>
</tr>
<tr>
<td></td>
<td>b. Participants’ perception of the program’s impact on their health status.</td>
<td>Patient survey</td>
<td>Data collected at 3, 6 and 12 months by the Program Coordinator</td>
</tr>
<tr>
<td>3. Are participants using fewer clinical and hospital ER services?</td>
<td>a. Participants’ utilization of clinic services (compared to non-participants) (i.e., number of visits, and types of services accessed).</td>
<td>Document review of Clinic EMR</td>
<td>Data collected semi-annually by the Program Coordinator</td>
</tr>
<tr>
<td></td>
<td>b. # of visits to the hospital ER for diabetes related complications (compare participants with diabetic patients who are non-participants)</td>
<td>Document review of Hospital EMR</td>
<td>Data collected at end of data collection phase by the Program Coordinator</td>
</tr>
<tr>
<td></td>
<td>c. Participants’ hospital admissions for diabetic related complications after participation in the DMP program (self-report)</td>
<td>Patient survey</td>
<td>Data collected at 3, 6 and 12 months by the Program Coordinator</td>
</tr>
<tr>
<td>4. Are participants satisfied with the care they are receiving through the program?</td>
<td>a. Participants’ reported levels of satisfaction with the DMP program</td>
<td>Patient survey</td>
<td>Data collected at 3, 6 and 12 months by the Program Coordinator</td>
</tr>
</tbody>
</table>
Grounded in science. Built on partnerships. Focused on results.