DP18-1817 | 2018 – 2021 Performance Measures Snapshot

Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes and Heart Disease and Stroke

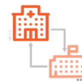
Cardiovascular Disease Prevention and Management

Cardiovascular disease is the leading cause of death in the United States. The CDC-funded DP18-1817 cooperative agreement supports **25 state and local health departments** to design, implement, and evaluate innovative approaches to reduce risk, complications, and barriers for the prevention and management of cardiovascular disease among priority populations. State and local health departments (recipients) are working with health care systems and community partners to **enhance adoption and use of clinical quality measures** (CQMs) , **explore new approaches to team-based care** (TBC), and; **expand community-clinical linkages** (CCL).

Supporting Priority Populations Through Innovative Interventions

Tracking & Monitoring

Team Based Care



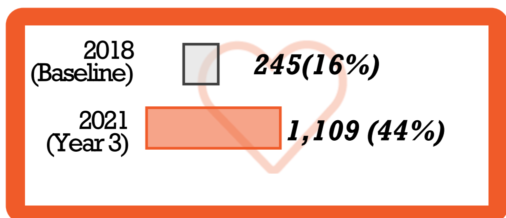
Linked Services

This snapshot reflects cumulative progress reported by recipients through performance measure data from Baseline (2018) to Year 3 (2021) and outcomes specific to the selected health care systems recipients worked with in Year 3.
Performance measure counts (numerators) reflect outcomes specific to the selected program sites the recipients worked with in Year 3, while denominators reflect the program sites the recipient is expecting to work with by Year 5.

Enhance Adoption and Use of Clinical Quality Measures

*DP18-1817 recipients have engaged health care systems and clinics to **identify patients with undiagnosed hypertension** and **explore and test innovative** ways to promote the adoption of evidence-based **quality measurement** at the provider level.*

Number of providers that have a protocol for identifying patients with undiagnosed hypertension



Based on innovative quality measurement activities for high blood pressure and high blood cholesterol:

64,866 (50%) patients with known high blood pressure within high-burden subpopulations have achieved **blood pressure control**

33,484 (45%) patients at high-risk of cardiovascular events within high-burden subpopulations have their **cholesterol managed** with statin therapy

Number (percentage) of clinics and health care system sites that are using CQMs to track disparities in:

63 (65%) *High blood pressure control*

56 (62%) *Cholesterol management*

Explore New Approaches to Team-Based Care

*DP18-1817 recipients are testing **new ways to engage non-physician team members** in clinical settings and **promoting the adoption of medication therapy management (MTM)** between community pharmacists and physicians to better manage high blood pressure, high blood cholesterol, and lifestyle modification.*

8,203 (8%) eligible patients with high blood pressure and/or high blood cholesterol received pharmacist-provided MTM services

88 (17%) community pharmacies are providing MTM services for patients with high blood pressure and/or high blood cholesterol

644 (6%) community pharmacists are providing MTM services for patients with high blood pressure and/or high blood cholesterol

Based on innovative engagement of non-physician team members:

114,352 *patients with known high blood pressure have achieved **blood pressure control***

2018 (Baseline) 55%

2021 (Year 3) 52%

96,544 *patients considered at high-risk for cardiovascular events have their **cholesterol managed with statin therapy***

2018 (Baseline) 59%

2021 (Year 3) 64%

30,000 patients = (one person icon)

Note: Based on recipient reported data from September 30, 2020 to September 29, 2021; the number of recipients reporting differs for each measure

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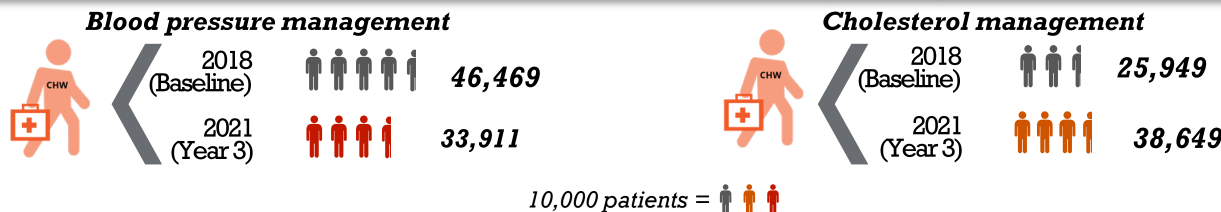
Expand Community-Clinical Linkages

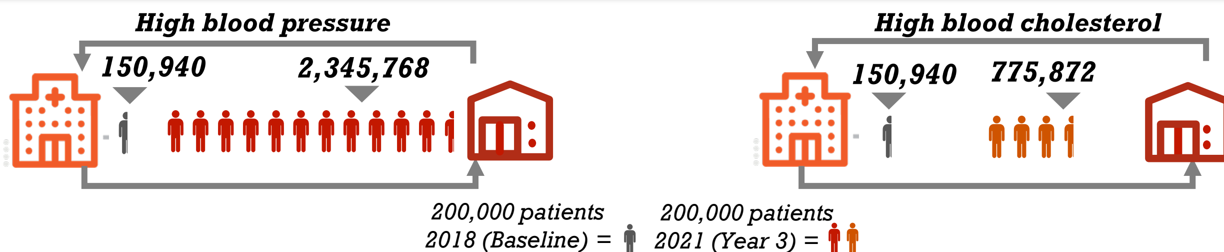
*DP18-1817 recipients are facilitating patient management of high blood pressure and high blood cholesterol through the **engagement of community health workers (CHWs) and patient navigators**; use of **telehealth and bidirectional referral systems**; and implementation of new approaches for **patient referral, participation, and adherence in cardiac rehabilitation programs**.*

Patients within clinical and/or community settings that had an encounter with a CHW or community navigator who linked them to community resources promoting:



10,000 patients =

Patients within health care systems that have implemented systems to track bi-directional referrals to evidence-based lifestyle programs for people with:



200,000 patients 2018 (Baseline) =

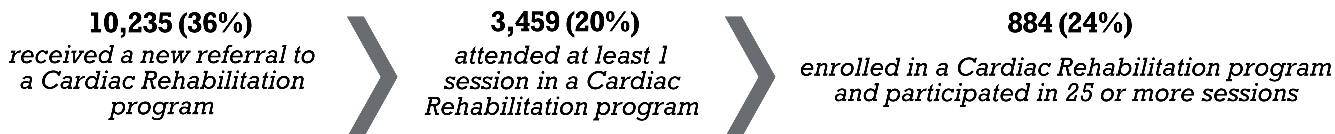
200,000 patients 2021 (Year 3) =

Patients within clinical and/or community settings using telehealth technologies to manage their:

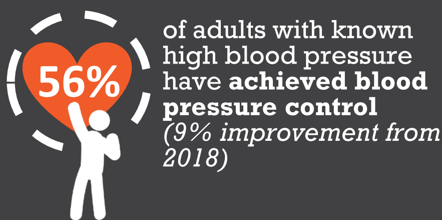
High blood pressure
20,403 (7%)

High blood cholesterol
6,550 (3%)

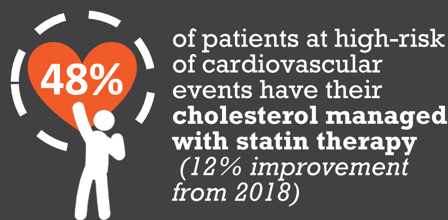
Eligible patients within clinical and community settings who:



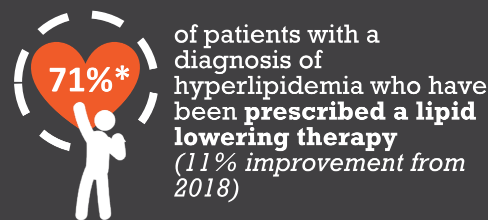
These efforts have ultimately reduced cardiovascular disease risks among adults with known high blood pressure and high blood cholesterol.



of adults with known high blood pressure have **achieved blood pressure control** *(9% improvement from 2018)*



of patients at high-risk of cardiovascular events have their **cholesterol managed with statin therapy** *(12% improvement from 2018)*



of patients with a diagnosis of hyperlipidemia who have been **prescribed a lipid lowering therapy** *(11% improvement from 2018)*

Note: Based on recipient reported data from September 30, 2020 to September 29, 2021; the number of recipients reporting differs for each measure. Data represents proportional progress achieved to date with respect to total population each recipient aims to engage by target year 2023.

For more information, please contact DHDSPEvaluation@cdc.gov. DRAFT:4/27/2022