Four distinct CDC chronic disease prevention programs are working together to strengthen state actions to address health risk behaviors, environments, and systems associated with diabetes, heart disease, obesity, and school health.

The following is a snapshot of select performance measures reported by the 1305 grantees in Year 4 of the program.

**States worked within different community settings—including worksites—to improve nutrition and physical activity**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Year 4</th>
<th>Change</th>
<th>Target</th>
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<tbody>
<tr>
<td>Physical Activity (PA) Policies</td>
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<td>3,685 worksites have adopted PA policies</td>
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<td>1,293</td>
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<td>3,690</td>
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<td>Nutrition guidelines</td>
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<td>1,838</td>
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<td>2,319</td>
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<td>2,343 worksites have adopted nutrition</td>
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<td>guidelines</td>
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<tr>
<td>States worked with local education agencies (LEAs) to improve nutrition, physical education, and the management of chronic conditions in schools</td>
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- **7,672** LEAs with over **29.3 million** students were supported in creating healthy school nutrition environments (Y5 Target: **7,757** LEAs, **29.5 million** students).
- **3,222** LEAs with over **19.3 million** students were supported in creating physical education policies (Y5 Target: **4,424** LEAs, **20 million** students).
- **218** LEAs with over **1.5 million** students were supported in establishing, implementing, and evaluating CSPAP (Y5 Target: **294** LEAs, **2.1 million** students).
- **53** LEAs supported in assessment, counseling, and referrals to community-based medical care providers for students on activity, diet, and weight-related chronic conditions (Y5 Target: **73** LEAs).

Note: Based on grantee reported data from Year 4 annual progress report (2017); the number of grantees reporting differs for each measure.
**Improved diagnosis and prevention of heart disease & stroke within health care systems**

Effective use of electronic health record (EHR) systems and promotion of quality improvement and population reporting of patients aged 18 to 85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement period (National Quality Forum (NQF) Measure 0018), improves identification and monitoring of diagnosed and undiagnosed patients with uncontrolled high blood pressure. Use of multidisciplinary team care improves the quality of care provided to patients with hypertension.

**Percent of health care systems:**

- **82%** with EHRs appropriate for treating high blood pressure
- **58%** with policies promoting multidisciplinary care team approach
- **76%** Reporting on NQF 0018

**Estimated number of patients within these health care systems**

- **30.8 million**
- **24.3 million**

**61.3%** of adults with known high blood pressure have achieved blood pressure control (6% improvement from baseline)

Note: The number of grantees reporting and data source types differ for each measure.

**Increased use of community-based diabetes prevention and self-management education programs**

**The National Diabetes Prevention Program (DPP)**

supports a structured, year-long lifestyle change program that is offered in-person and online to prevent or delay the onset of type 2 diabetes among those at high risk. States are working to increase prediabetes awareness, increase referrals to CDC-recognized diabetes prevention programs, and secure the program as a covered benefit for state or public employees and Medicaid beneficiaries.

**Improved referral policies**

- **34.4%** of health care systems have policies to refer persons at high risk for type 2 diabetes to a CDC-recognized diabetes prevention program (increase of 17.2% from baseline).

**Improved Medicaid coverage**

- **628,275** Medicaid beneficiaries now have access to a CDC-recognized diabetes prevention program as a covered benefit (increase from 30,224 beneficiaries at baseline).

**Increased use**

- **90,952** people with prediabetes or at high risk for type 2 diabetes enrolled in a CDC-recognized diabetes prevention program.
- **50%** of participants were referred by a health care provider.

**Diabetes Self-Management Education (DSME)**

is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care to improve clinical outcomes, health status, and quality of life. The 1305 grantees are working to increase use of DSME by increasing referrals to, coverage for, and availability of programs.

**Increased availability**

- **3,045** ADA-recognized and AADE-accredited DSME programs were offered across 58.8% of counties in 40 states (net increase of 5.5% from baseline).

**Improved Medicaid coverage**

- **2.6 million** Medicaid beneficiaries now have DSME as a covered benefit (26% increase from baseline).

**1 million** people with diabetes participated in an American Diabetes Association (ADA)-recognized or American Association of Diabetes Educators (AADE)-accredited DSME program in targeted settings (12% increase from baseline).

*Note: Based on grantee reported data from Year 4 annual progress report (2017); the number of grantees reporting differs for each measure*