



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

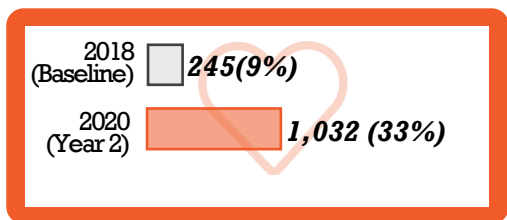
This snapshot reflects cumulative progress reported by recipients through performance measure data from Baseline (2018) to Year 2 (2020) and outcomes specific to the selected health care systems recipients worked within Year 2.

Performance measure counts (numerators) reflect outcomes specific to the selected program sites the recipients worked within Year 2, 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:

202,070 (62%) “patients with known high blood pressure within high-burden subpopulations have achieved **blood pressure control**”

80,152 (59%) “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:

242 (40%)
High blood pressure control

200 (33%)
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**.

832 (1%) eligible patients with high blood pressure and/or high blood cholesterol received pharmacist-provided MTM services

194 (31%) community pharmacies are providing MTM services for patients with high blood pressure and/or high blood cholesterol

610 (6%) community pharmacists are providing MTM services for patients with high blood pressure and/or high blood cholesterol

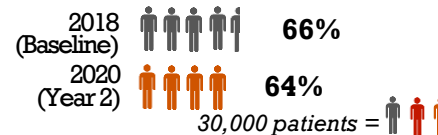


Based on innovative engagement of non-physician team members:

274,908 patients with known high blood pressure have achieved **blood pressure control**



122,504 patients considered at high-risk for cardiovascular events have their **cholesterol managed with statin therapy**

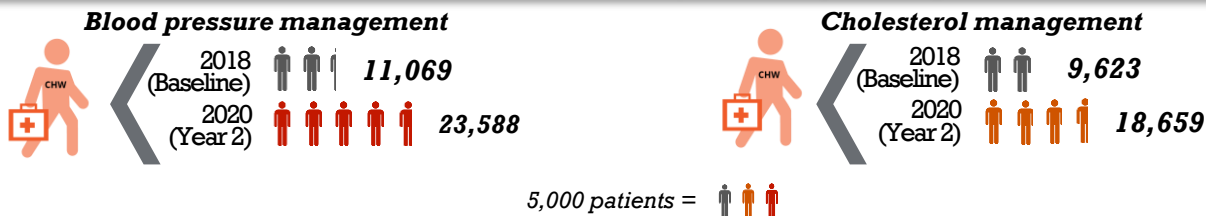




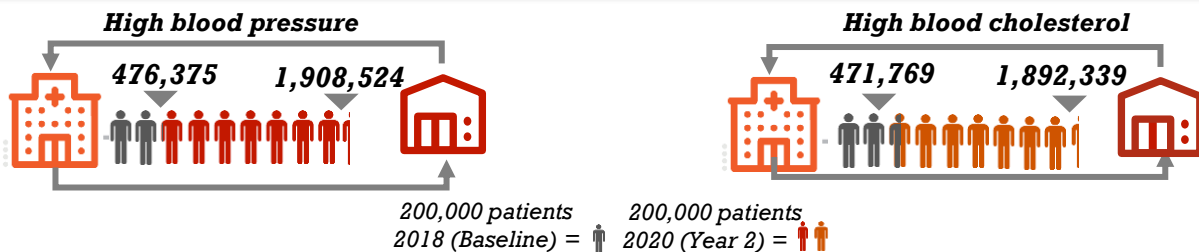
Expand Community-Clinical Linkages

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:



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



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

High blood pressure
11,133 (2%)
 in 2020 (Year 2)



High blood cholesterol
5,212 (2%)
 in 2020 (Year 2)

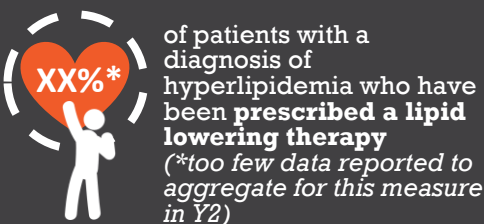
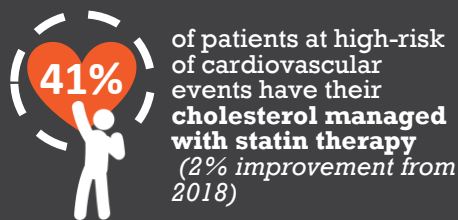
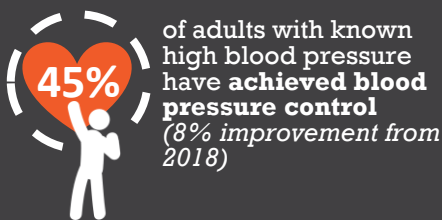
Eligible patients within clinical and community settings who:

10,532 (36%)
 received a new referral to a Cardiac Rehabilitation program

2,168 (15%)
 attended at least 1 session in a Cardiac Rehabilitation program

764 (17%)
 enrolled in a Cardiac Rehabilitation program and participated in 25 or more sessions

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



Note: Based on recipient reported data from September 30, 2019 to September 29, 2020; 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: 10/26/2021

