VERMONT
DEPARTMENT OF HEALTH

Health Systems Approaches to Preventing and Managing Diabetes and Heart Disease

October 2022

Through the *Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke* (CDC-RFA-DP-1815) cooperative agreement with the Centers for Disease Control and Prevention (CDC), health organizations partnering with the Vermont Department of Health are working to increase the identification of patients with undiagnosed or uncontrolled chronic conditions (prediabetes, diabetes, hypertension, and high cholesterol), improve provider and patient outcomes utilizing health information technology and referral to lifestyle change and self-management programs, utilizing team-based care.

These data describe the measures identified by the CDC to evaluate the impact of the grant strategies. Comparisons represent all U.S. states currently submitting data to the CDC for each measure.

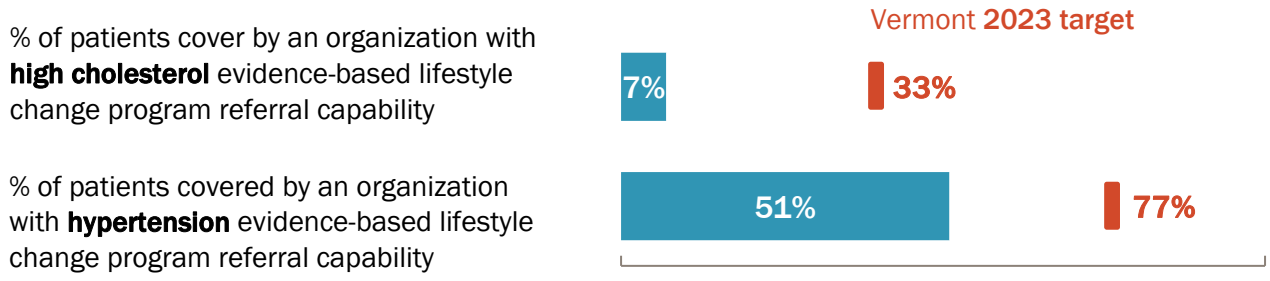
KEY POINTS

- **All partnering health organizations use standardized CQMs to report hypertension diagnosis, management, and treatment.**
- **Proportion of patients with hypertension in control increased from 2020 to 2021.**

Referring to Lifestyle Change Programs

Vermont-partnering health organizations that refer patients to evidenced-based lifestyle change programs for hypertension served a higher proportion of patients between the ages of 18 and 85 than those that refer to evidence-based lifestyle change programs for high cholesterol (51% vs. 7%, respectively).

Over half of patients (18-85 years old) in Vermont-partnering health organizations are covered by an organization that refers patients to a lifestyle change program for hypertension



As of 2021, two in five (40%) patients are covered by a Vermont-partnering health organization that have a process to identify patients with prediabetes and refer them to a CDC-recognized lifestyle change program.

Two in five patients are served by a Vermont-partnering health organization with a process to identify and refer people with prediabetes to a CDC-recognized lifestyle change program

Data Source: Vermont Health Systems Quality Improvement Assessment (VHSQIA), 2021.

Chronic Condition Management

Eight Vermont-partnering health organizations provide direct patient care. These organizations cover 82,997 Vermont adults between the ages of 18 and 85 years old. All (100% of covered patients) have a system to report standardized clinical quality measures (CQMs) for the management and treatment of patients with hypertension. This is higher than the 80% of U.S. health organizations with similar capabilities, meeting the Vermont 2022 target. While all organizations providing direct patient care report standardized CQMs for hypertension diagnosis, management, and treatment, far fewer used these CQMs to track differences in hypertension control or cholesterol management among priority populations (e.g. age, sex, race/ethnicity, sexual orientation/gender identity, or people with disabilities). Only a third (33%) use standardized CQMs to track hypertension control in priority populations while 11% track differences in cholesterol management. This is fewer than the 67% and 50% of patients attributed to U.S. partnering health organizations, respectively, who use standardized CQMs for those purposes.

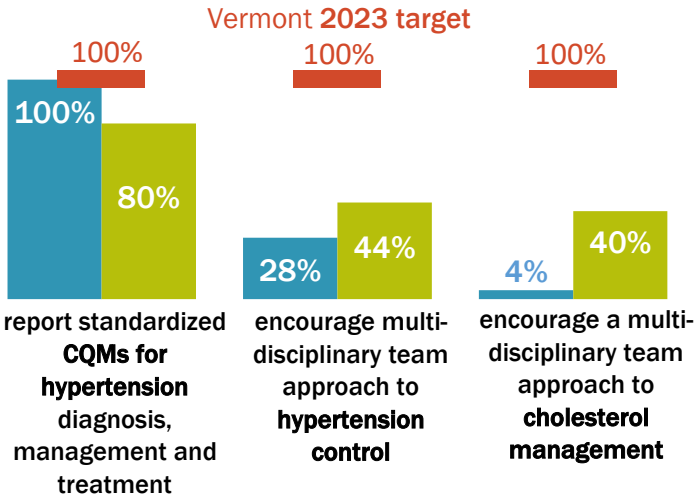
Healthcare support services are provided by nine Vermont-partnering health organizations, which cover 86,878 patients (18-85 years old). Six of the nine, accounting for 28% of covered patients, encourage a multi-disciplinary team-based approach to hypertension control; this is lower than the 44% of U.S. patients covered by health organizations with similar approaches. Fewer patients were covered by a Vermont-partnering health organizations that use a multidisciplinary team-based approach for cholesterol management (4%), well below the 40% of U.S. patients attributed to health organizations taking a similar approach to cholesterol management. By the end of 2023, all partnering health organizations providing healthcare support will use a team-based approach to hypertension control and cholesterol management.

33% of Vermont and **67% of U.S.** health organizations use standardized CQMs to track differences in **hypertension control** in priority populations.

11% of Vermont and **50% of U.S.** health organizations have systems in place that use standardized CQMs to track differences in **cholesterol management** in priority populations.

Data Source: VHSQIA, 2021; CDC, 2021

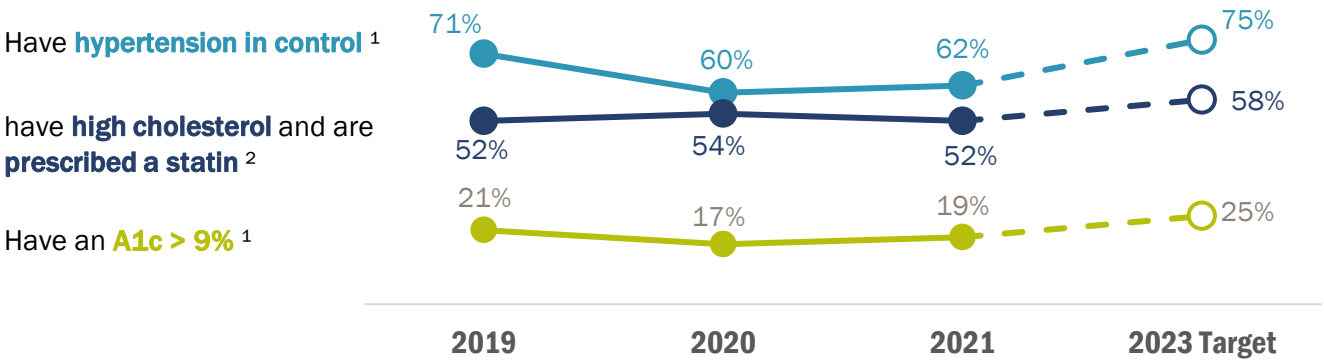
Percent of Patients in Partnering Health Systems in Vermont and the U.S. that Have Systems or Policies in place to...



Clinical Outcomes

From 2019 to 2021 the rate of hypertension control decreased from 71% to 62%, indicting that fewer patients with hypertension have it well managed. Diabetes not in control (A1c > 9%) also decreased from 2019 to 2021 from 21% to 19%, a positive change. However, from 2020 to 2021 there was a slight increase, indicating more patients with diabetes did not have their condition in control. The proportion of patients with high cholesterol prescribed a statin held relatively stable from 2019 to 2021 at between 52% and 54% with a slight decrease from 2020 to 2021. The decreases in the proportion of patients with hypertension and diabetes who have it in control as well as statin prescription coverage for patients with high cholesterol are all potentially related to decreases in healthcare visits during the COVID-19 pandemic.

Percent of Patients Attributed to Partnering Health Organizations Who...



Data Notes: Statin prescriptions were identified in claims data using national drug codes (NDC) provided by the Pharmacy Quality Alliance (PQA).

Data Source: [1] Vermont partnering health organization grantee reports, 2019-2021. [2] Green Mountain Care Board (GMCB), Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), 2019-2021 – extract 3004 – extracted 08/25/22.

Key Takeaways

Among measures intended to show shorter term change, those related to referrals to lifestyle change programs and chronic disease management, Vermont-partnering health organizations have shown reasonable progress towards 2022 targets. However, measures intended to show longer-term results, those related to clinical outcomes, have overall shown a trend in the negative direction. This negative trend is highly likely due to decreases in healthcare visits during the COVID-19 pandemic. Activities planned for 2022/2023 are designed to ensure that planned 2023 targets will be met.

For more information: Paul Meddaugh, paul.meddaugh@vermont.gov