Guidance for Tracking and Monitoring Key Clinical Measures for Groups with Hypertension and High Cholesterol

Background

Cardiovascular disease (CVD) and stroke are among the most significant causes of disability and death in Wisconsin. While CVD and stroke are common, they do not impact Wisconsin residents equally. Nonmedical factors, such as differences in primary care access, education, economic status, unemployment, transportation, and other social drivers of health (SDoH) mean that certain populations may experience a higher prevalence of these conditions with adverse effects, including death.

In 2020, CVD was the leading cause of death in Wisconsin, taking more than 12,000 Wisconsinites from their families, and stroke was the fifth leading cause of death, impacting more than 1,900 people[1,2]. Differences persist in CVD deaths; about six in 10 CVD deaths were male Wisconsin residents, and about one in 10 CVD deaths were residents who identify as Black[2]. These trends in CVD deaths have remained the same since 2010[3].

The Wisconsin Department of Health Services (DHS) Chronic Disease Prevention Program (CDPP) is partnering with organizations across Wisconsin to improve cardiovascular health and reduce disease impact for all residents. We will measure our success through increased blood pressure and blood cholesterol control rates, with a particular focus on those at greatest risk.

Using demographic and clinical data to identify and track progress to reduce CVD

While the data shows differences across Wisconsin, research also reveals even greater variations between populations in the same geographic area and even among neighborhoods within the same region. Electronic Health Record (EHR) data can be used to identify which populations within a health system are experiencing worse blood pressure and cholesterol control. This information can inform the implementation of focused outreach and interventions to meet the needs of those at greatest risk.

Our goal is for all health care partners to have policies and protocols in place requiring the use of EHRs and standardized clinical quality measures to track hypertension control measures by various demographics measures. CDPP and our partners can work with health systems to document workflows for pulling and utilizing this data, and implementing quality improvement initiatives to improve hypertension (HTN) and high blood cholesterol (HBC) for priority populations.

Citations

1. Centers for Disease Control and Prevention. National Center for Health Statistics - Wisconsin Key Health Indicators. Accessed on March 22, 2023. Available online: https://www.cdc.gov/nchs/pressroom/states/wisconsin/wi.htm.
2. Centers for Disease Control and Prevention. Interactive Atlas of Heart Disease and Stroke. Accessed on March 22, 2023. Available online: http://nccd.cdc.gov/DHDSPAtlas.
3. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Chronic Disease Indicators (CDI) Data. Accessed March 22, 2023. Available online: https://nccd.cdc.gov/cdi.

Parameters for pulling an initial report

Use the following parameters to pull an initial report on HTN and HBC control in the reporting period of January 1–December 31 of the desired year care was provided. If you already report standardized clinical quality measures for the identification, management and treatment of patients with HTN and HBC, you can use that to submit the data below.

High Blood Pressure or Hypertension (HTN)

- Total number of patients aged 18—85
- Number of patients with a diagnosis of HTN (indicate what CQM you are tracking such as CMS 165, NQF 18, PQRS 236 or what guidelines you are using such as ACC/AHA or JNC-7)
- Of those with an HTN diagnosis, number of patients with uncontrolled blood pressure >140/90
- Of those with an HTN diagnosis, number of patients who screened positive for a social driver of health need (SDoH) (yes/no/not screened) If yes, include which SDoH need identified
- Stratify all groups of patients by demographic data (including sex, race or ethnicity, primary language, age, zip code, and primary payer)

High Blood Cholesterol (HBC)

- Total number of patients aged 21 and older
- Number of patients who meet one or more of the criteria that are considered at high risk for cardiovascular events, under ACC/AHA guidelines
- Of those, number of patients who received at least one order (prescription) for statin therapy
- Number of patients who screened positive for a social driver of health need (yes/no/not screened) If yes, include which SDoH need identified
- Stratify all groups of patients by demographic data (including sex, race or ethnicity, primary language, age, zip code, and primary payer)

Next steps

Work with CDPP and our partners to utilize this data to identify populations experiencing higher rates of uncontrolled HTN and/or HBC and design a quality improvement project to best meet their needs. Example initiatives could include but are not limited to:

- Focused outreach to connect patients with chronic care management.
- Connection to a community health worker (CHW) or social worker to address non-clinical needs.
- Connection to a pharmacist for medication therapy management.
- Connection to a lifestyle change or self-measured blood pressure program.

Initiatives should be customized to meet the specific needs of the community and continuous monitoring should be done to evaluate progress in improving outcomes.

We are here to help

Chronic Disease Prevention Program
DHSChronicDiseasePrevention@dhs.wisconsin.gov

WISCONSIN DEPARTMENT of HEALTH SERVICES
P-03703 (03/2025)