FAMILY HEALTH AND WELLNESS
CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

CDC2304 and CDC2320

Priority Population Definitions

&

General Approaches to Reporting on Impact

May 2025

Contents

Priority Population Definitions: CDC2320 (Diabetes) 3

CDC2320 Twenty-Five (25) Priority Counties 3

Priority Population Definitions CDC2304 (Cardiovascular) 5

CDC2304 Thirty-Six (36) Priority Counties 5

CDC2304: Forty-Nine (49) Priority Census Tracts 9

CDC2304: Priority Census Tract Clusters 10

General Approaches to Reporting Impact 12

Priority Population Definitions: CDC2320 (Diabetes)

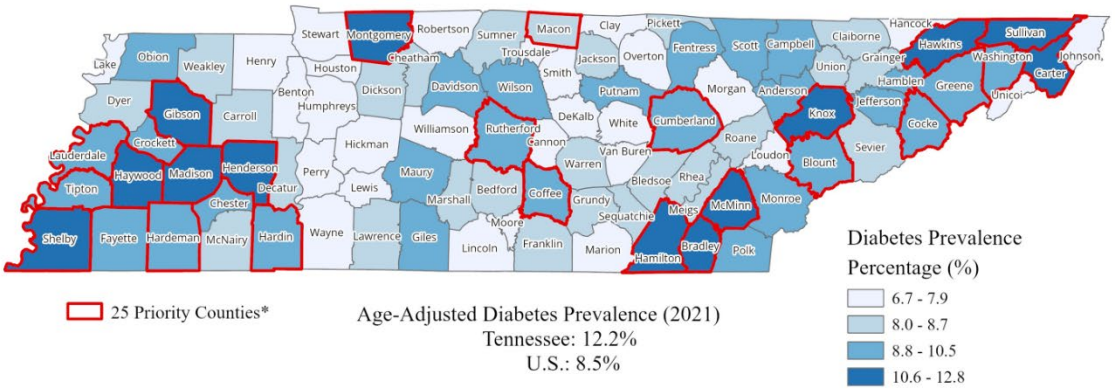
CDC2320 priority populations include all Tennesseans that are at risk for (or have already been told by a doctor they have) a diabetes diagnosis. Data show that populations at the highest risk include Black or African/Non-Hispanic Tennesseans, those aged 45 years and older, those with less than a high school education, and/or those living in a low-income household (<$25,000). These priority populations must be reached within the places where they reside, which include 25 counties.

CDC2320 Twenty-Five (25) Priority Counties**:** Blount, Carter, Cocke, Coffee, Cumberland, Gibson, Greene, Hamilton, Hardeman, Hardin, Hawkins, Haywood, Henderson, Knox, Lauderdale, Macon, Madison, McMinn, Montgomery, Rutherford, Shelby, Sullivan, Tipton, and Washington

Bradley	Cumberland	Hardin	Lauderdale	Rutherford
Blount	Gibson	Hawkins	Macon	Shelby
Carter	Greene	Haywood	Madison	Sullivan
Cocke	Hamilton	Henderson	McMinn	Tipton
Coffee	Hardeman	Knox	Montgomery	Washington

Table 1: Tennessee High Risk Priority Populations for Diabetes and Prediabetes (2023, BRFSS) Tennessee State Prevalence (Diabetes: 14.6%; Prediabetes: 14.3%)
Age Ages 45-54 (Diabetes: 16.3%; Prediabetes: 14.1%) Ages 55-64 (Diabetes: 22.4%; Prediabetes: 21.2%) Ages 65+ (Diabetes: 27.3%; Prediabetes: 21.1%)
Race Black or African American/Non-Hispanic (Diabetes: 21.5%; Prediabetes: 17.9%)
Household Income Below $15,0000/year (Diabetes: 22.4%; Prediabetes: 19.8%) $15,000-$24,999/year (Diabetes: 25.2%; Prediabetes: 16.9%)
Educational Attainment Less than High School: (Diabetes: 21.2%; Prediabetes: 22.1%)

2021 Statewide Age-Adjusted Diabetes Prevalence by County

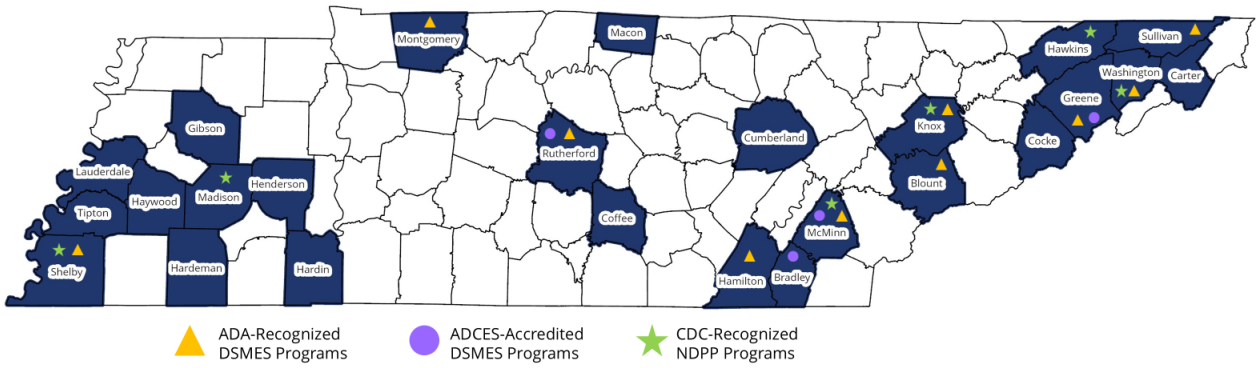


Note:
Prevalence of diabetes is the percentage of the adult population (aged 20+ years) who have been told they have diabetes by county which is based on 2021 estimates from the BRFSS.

Data Source:
Centers for Disease Control and Prevention Diabetes Surveillance System, 2021

TN

Tennessee Priority Counties with ADA/ADCES DSMES and NDPP



Data Sources:
Centers for Disease Control and Prevention Diabetes Surveillance System, 2021
ADA Programs Report, January 2025
ADCES DEAP Programs Report, January 2025
CDC DPRP Registry Report, January 2025

TN

Priority Population Definitions CDC2304 (Cardiovascular)

CDC2304 priority populations include all Tennesseans that are at high risk for (or have already been told by a doctor they have) a cardiovascular diagnosis*. Data show that populations at the highest risk include both Black and White Tennesseans, those 55 years and older**, those with less than a high school education, and/or those living in a low-income household (<$25K/year). These priority populations must be reached within the places where they reside, which include thirty-six (36) counties as well forty-nine (49) census tracts of interest.

**Primary cardiovascular diagnoses of interest include high blood pressure, high blood cholesterol, angina, coronary heart disease, stroke, and obesity. **For blood cholesterol screening and referral efforts, the priority populations also include American Indian, Asian, and persons under age 35.*

CDC2304 Thirty-Six (36) Priority Counties: Bedford, Benton, Campbell, Carroll, Chester, Clay, Claiborne, Cocke, Crockett, Cumberland, Decatur, Dyer, Fentress, Gibson, Giles, Grundy, Hancock, Hardeman, Hardin, Henderson, Henry, Humphreys, Johnson, Lake, Lauderdale, Laurence, Lincoln, Marshall, McMinn, McNairy, Meigs, Obion, Perry, Polk, Scott, Unicoi

Bedford	Claiborne	Fentress	Hardin	Lauderdale	Meigs
Benton	Cocke	Gibson	Henderson	Laurence	Obion
Campbell	Crockett	Giles	Henry	Lincoln	Perry
Carroll	Cumberland	Grundy	Humphreys	Marshall	Polk
Chester	Decatur	Hancock	Johnson	McMinn	Scott
Clay	Dyer	Hardeman	Lake	McNairy	Unicoi

Table 2: Tennessee High Risk Priority Populations for <u>Cardiovascular Disease Mortality (Cause of Death)</u> (2019-2021 CDC Interactive Atlas of Heart Disease and Stroke) Tennessee State Rate (Ages 35+): 531.6 per 100,000 Population
<u>Age</u> Ages 35-64 (163.6 per 100,000) Ages 65+ (1651.7 per 100,000)
<u>Race</u> Black non-Hispanic (593.8 per 100,000) White non-Hispanic (437.7 per 100,000)

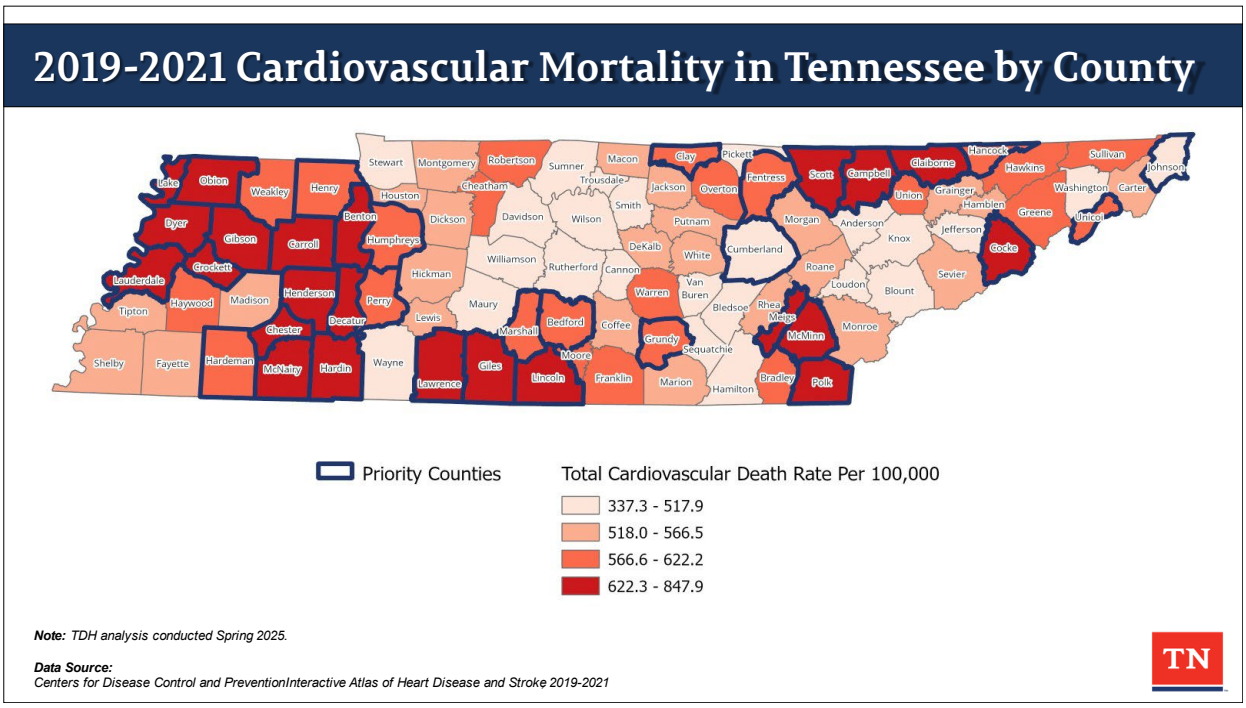


Table 3: Tennessee High Risk Priority Populations for <u>Coronary Heart Disease</u> (2023, BRFSS) Tennessee State Rate: 5.1%
<u>Age</u> Ages 55-64 (8.2%) Ages 65+ (11.9%)
<u>Race</u> Black or African American/non-Hispanic (4.0%) White non-Hispanic (5.4%)
<u>Income</u> <$15,000/year (11.8%) $15,000-$24,999/year (8.3%)
<u>Educational Attainment</u> Less than High School: (10.9%)

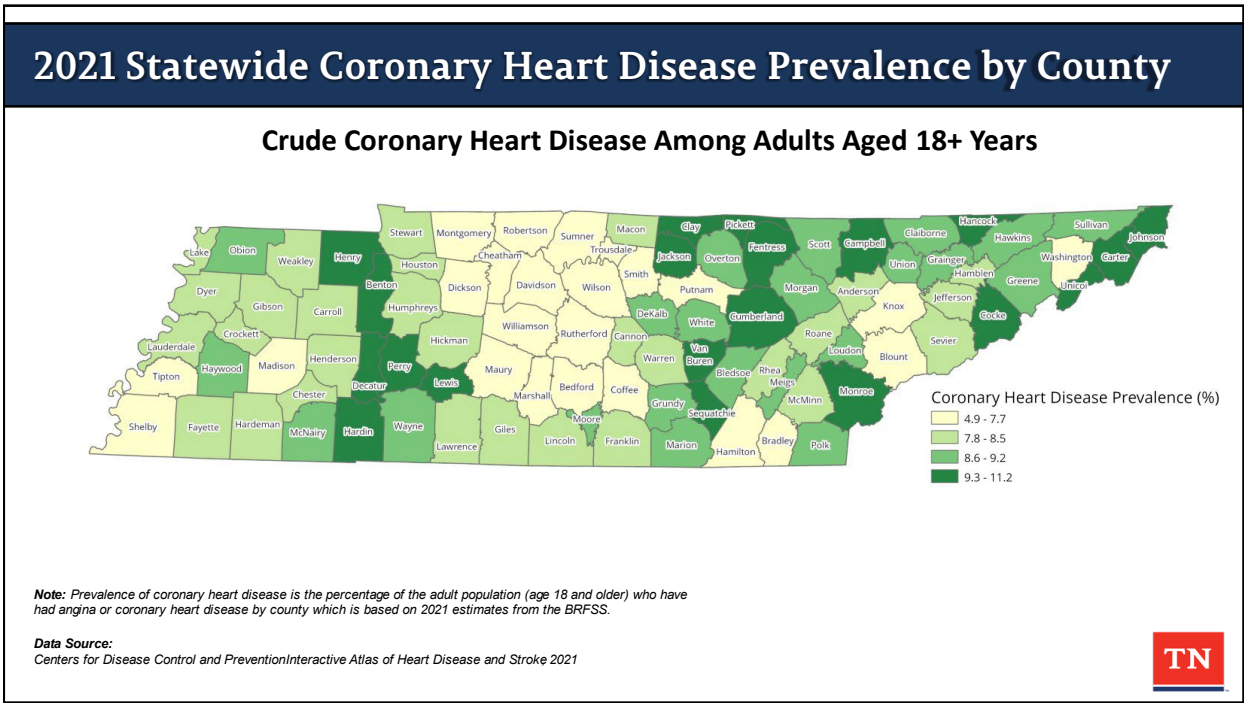
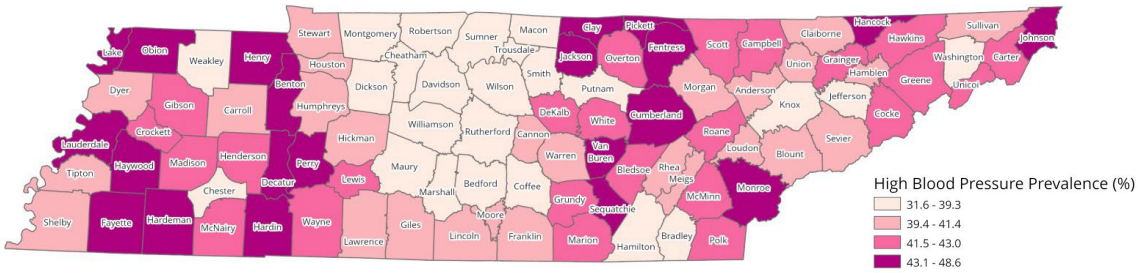


Table 4: Tennessee High Risk Priority Populations for <u>Hypertension</u> (High Blood Pressure) (2023, BRFSS) Tennessee State Rate: 40.7%
<u>Age</u> Ages 55-64 (54.1%) Ages 65+ (68.3%)
<u>Race</u> Black or African American/non-Hispanic (51.4%) White /non-Hispanic (40.0%)
<u>Income</u> <$15,000/year (52.9%) $15,000-$24,999/year (56.3%)
<u>Educational Attainment</u> Less than High School: (51.8%)

2021 Statewide High Blood Pressure Prevalence by County

Crude High Blood Pressure Among Adults Aged 18+ Years



Note: *Prevalence of high blood pressure is the percentage of the adult population (age 18 and older) who have been told they have high blood pressure by county which is based on 2021 estimates from the BRFSS.*

Data Source:
Centers for Disease Control and PreventionInteractive Atlas of Heart Disease and Stroke 2021

TN

CDC2304: Forty-Nine (49) Priority Census Tracts

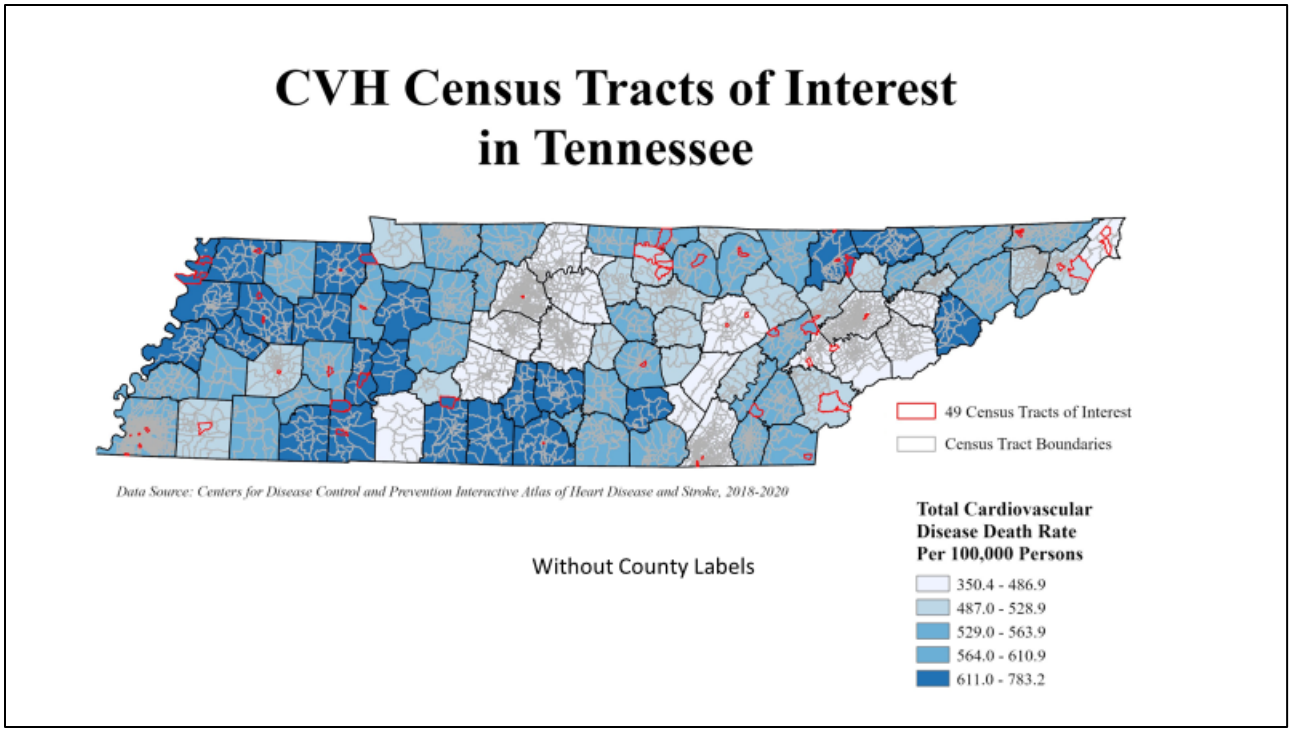
County	County Population 18+ in Priority CTs	TN Priority CTs	CT Population 18+	Priority Indicators (10%) C,S,H,B
Anderson	3454	47001020202	3454	CHB
Benton	3256	47005963400	3256	CSH
Campbell	7832	47013950200	1888	CSHB
		47013950700	3750	CSH
		47013950900	2194	CSH
Carter	3413	47019070600	2152	CSHB
		47019071600	1261	CSHB
Clay	4006	47027955000	4006	CSHB
Cumberland	10056	47035970101	4483	CSHB
		47035970102	5573	CSHB
Davidson	1030	47037013900	1030	SHB
Decatur	1419	47039955101	1419	CHB
Fayette	3558	47047060501	3558	SHB
Fentress	3406	47049965100	3406	CSHB
Gibson	6481	47053966700	4415	SHB
		47053966900	2066	SHB
Hamilton	3525	47065001200	2419	SHB
		47065002300	1106	SHB
Hardin	6848	47071920400	3766	CSHB
		47071920600	3082	CHB
Henderson	3760	47077975400	3760	SHB
Henry	7748	47079969000	3452	CHB
		47079969500	4296	CSHB
Jackson	3204	47087960100	1573	CHB
		47087960400	1631	CSHB
Johnson	5369	47091956000	873	CHB
		47091956300	4496	CSHB
Knox	4849	47093002100	2227	SHB
		47093003200	2622	SHB
Lake	1786	47095960200	1786	CSHB
Lauderdale	1853	47097050504	1853	SHB
Lawrence	3876	47099960501	3876	CSH
Lincoln	4531	47103975300	4531	CSH
Loudon	8184	47105060501	8184	CHB
Madison	694	47113001100	694	SB
McMinn	4628	47107970200	4628	SHB
Monroe	2645	47123925501	2645	CSHB
Obion	3032	47131965600	3032	SHB
Overton	2313	47133950302	2313	CSHB
Polk	3341	47139950400	3341	CSHB
Roane	3552	47145030500	3552	CSHB
Shelby	7810	47157002800	2121	SHB
		47157003000	2276	SHB
		47157003700	1067	SHB
		47157004600	987	SHB
		47157010500	1359	SHB
Sullivan	3786	47163040200	1630	CSHB
		47163040700	2156	CSHB
Warren	3105	47177930600	3105	CSHB
Total	**138350**	**Total**	**138350**	

County CT Clusters	CT Cluster Population 18+
Cumberland/Roane/Loudon	21792
Sullivan/Johnson/Carter	12568
Henry/Benton	11004
Monroe/McMinn/Polk	10614
Clay/Jackson/Overton	9523
Anderson/Knox	8303
Campbell	7832
Shelby	7810
Hardin	6848
Gibson	6481
Henderson/Decatur	5179
Hamilton	3525
Total	**111479**
Mean	**9289.9**
Median	**8067.5**

An original priority county

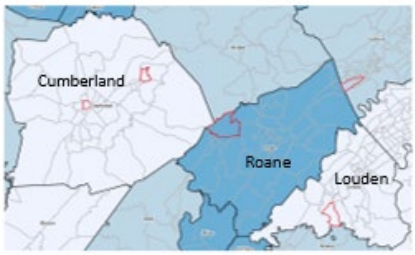
Abbreviations

CT - census tract
C - high blood cholesterol
S - stroke
H - coronary heart disease
B - high blood pressure

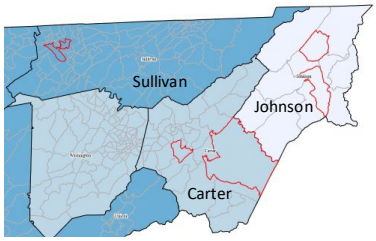


CDC2304: Priority Census Tract Clusters

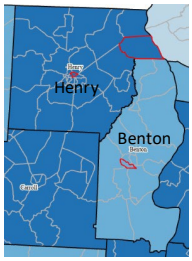
Cluster 1: Cumberland, Roane, and Louden



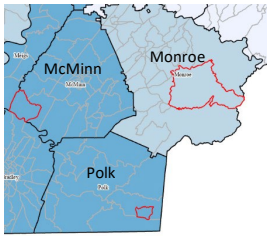
Cluster 2: Sullivan, Johnson, and Carter



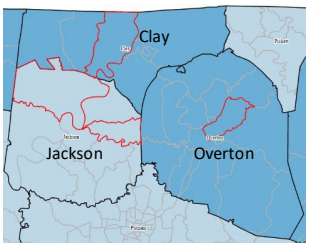
Cluster 3: Henry and Benton



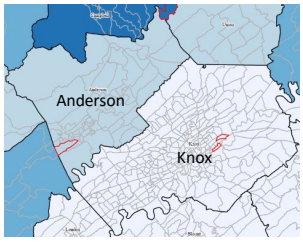
Cluster 4: McMinn, Monroe, and Polk



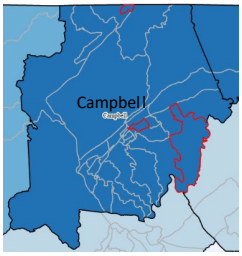
Cluster 5: Clay, Jackson, and Overton



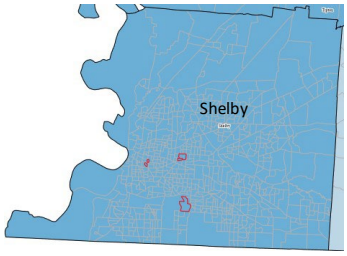
Cluster 6: Anderson and Knox



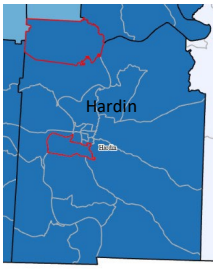
Cluster 7: Campbell



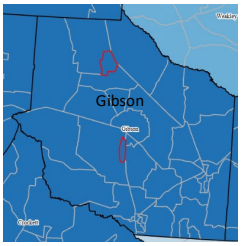
Cluster 8: Shelby



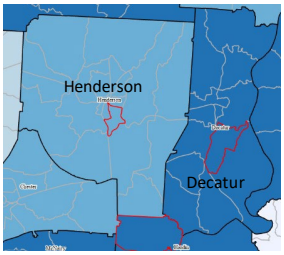
Cluster 9: Hardin



Cluster 10: Gibson



Cluster 11: Henderson and Decatur



Cluster 12: Hamilton

General Approaches to Reporting Impact

Contractors should use the Health Impact Brief sections of the REDCap reporting system to provide an annual narrative regarding their 2320 (diabetes) and 2304 (cardiovascular) interventions and initiatives. Please include a description and timeline of all activities and progress toward implementing strategies and achieving work plan goals and objectives. Also describe facilitators of success (i.e., best practices) as well as barriers and challenges and any strategies employed to resolve those issues and improve program performance. In addition, describe progress toward reaching priority populations (Appendices 1 and 2) to mitigate social determinants of health (SDOH) and reduce health disparities.

Please report in detail, any activities leading to policy, systems, and environmental changes (PSE) as well as increases in efficiency of operations through shared or combined partnerships, staffing, facilities, materials, funding, and other resources. In addition, how have programs planned for sustainability of efforts after the 2320 and 2304 agreements end, including obtaining additional funding, partnerships, and similar program supports?

Progress in implementing strategies and achieving goals should also be demonstrated by reporting key quantifiable performance measures and process outputs as defined and listed in the monthly contractor reporting template and the Performance Measure section of the annual REDCap reporting system.

The following is a more detailed description of data and information for inclusion in the REDCap report:

1. **Promotion and Awareness Related Initiatives:**

Events: Provide number, type(s), date, and location (county and census tract, if available) of health fairs, presentations, lunch and learns, direct contacts, employee meetings, media campaigns, professional development webinars (e.g., identifying/navigating social service needs), and similar activities.

Target audience(s): For events and media, provide number and type(s) of participants; attendees; contacts; targeted social media posts; billboard, radio, TV, print, other advertising; website links; etc. Where applicable, describe audiences and include exposures, views, impressions, hits, or reach. Also report any numbers related to tracking or follow-up of persons after events. Break down numbers by total as well as by priority populations listed in Appendices 1 and 2 below.

2. **Counseling, Patient Education, Lifestyle Change Programs (LCP), screening for chronic kidney disease (CKD) or diabetic retinopathy (DR), and Social Support Services**
   (*aggregate/total statistics only – do not report any patient/participant specific data*)

These activities include the following programs/interventions: DSMES, NDPP, MEND, *Live in Control*, and CKD and DR early detection (2320), as well as SMBP/ HHA (2304). Use the **IRECO** (Identification, Referral, Enrollment, Completion, and Outcomes) construct to report statistics as follows:

# of eligible patients/persons **identified** for prediabetes, diabetes, hypertension, hyperlipidemia, or CKD and DR early detection, etc. and the method(s) of identification as relates to potential participation in LCPs, clinical screening for complications, and social service programs.

# of these same patients/persons **referred** to LCPs, clinical screening, or social service programs broken down by the source of referral. If possible, describe referral tracking and follow-up methods, such as EHR, bi-directional information systems, "prescription" forms, tear off sheets/referral cards, incentives, and registration forms (e.g., where did you hear about this program?).

# of these same patients **enrolling** in a program or scheduling clinical screening

# of these same patients **completing** a program or clinical screening or retained in an NDPP (2320) leading to a reduction in their risk for type 2 diabetes.

Average change in any health, behavioral, or social service **outcomes** during the program or any after program follow-up (e.g., A1C, glucose levels, blood pressure, cholesterol levels, weight, activity minutes, social supports, etc.). For 2320 supported NDPPs, provide the same data that organizations report to the CDC Diabetes Prevention Recognition Program. For clinical screenings, include the number and percentage of patients screened and diagnosed for CKD or DR and referred for appropriate treatment.

Stratify number of participants/attendees by demographics (age, sex, race), socioeconomic status (income, education), social determinants of health (e.g., food assistance, transportation, housing, childcare, etc.), and location both overall (i.e., total) and by priority populations (see Appendices 1 and 2). Location should include counties (2304/2320) and census tracts (2304) with a focus on priority, high risk areas. Program registration forms could be useful for capturing these types of data.

3. Profile of Contractors, Health Care Organizations (include clinical measures), Social Service Agencies, employers, and Other State and Community Partners and Organizations.

Differentiate between partners that are identifying, providing, and referring patients and participants for counseling, education, LCPs, and professional development versus those that are actually providing services/training/counseling for these types of programs or both.

Number, type, name, address/location (county and/or census tract) of participating organizations (LHDs, community groups, faith-based organizations, hospitals, health providers, health provider organizations, community health centers, pharmacists/pharmacies, colleges/universities, social support agencies, etc.).

For community organizations: Provide the total number of members and what type of populations are served (low-income, elderly, women, men, children, adolescents, minorities, etc.). Use priority populations listed below as a guide. For state and private employers, not only describe the population of employees, but also indicate how many employees have NDPP as a covered health insurance benefit.

For patient care/health care delivery organizations (HCOs): Provide the total patient population as well as numbers by types of populations served (demographics, SES, SDOH, etc.). Do HCOs offer a multi-disciplinary team approach for disease/risk factor prevention and management as well as SDOH mitigation? Are there EHR/HIT systems that can identify patients (pre-diabetes, diabetes, hypertension, hyperlipidemia, and SDOH) and track and manage treatments and clinical outcomes? For managed care organizations, provide the number of Medicaid recipients with NDPP as a covered benefit.

Also describe community-clinical linkages, including the use of community health workers or equivalents for patient navigation related to prevention, clinical management, and social and support services.

**As every work plan is unique and involves a different mix of programs, strategies, and activities, only some of the information, measures, outputs, and outcomes listed above will be applicable to any given contractor. In addition, TDH realizes that not all data will be readily accessible or available, especially for Year 1. Therefore, please provide information regarding what measures are relevant to your program as well as barriers and challenges you experienced in obtaining performance or output data. Please describe plans or strategies you have for collecting any of this missing information in the future.*