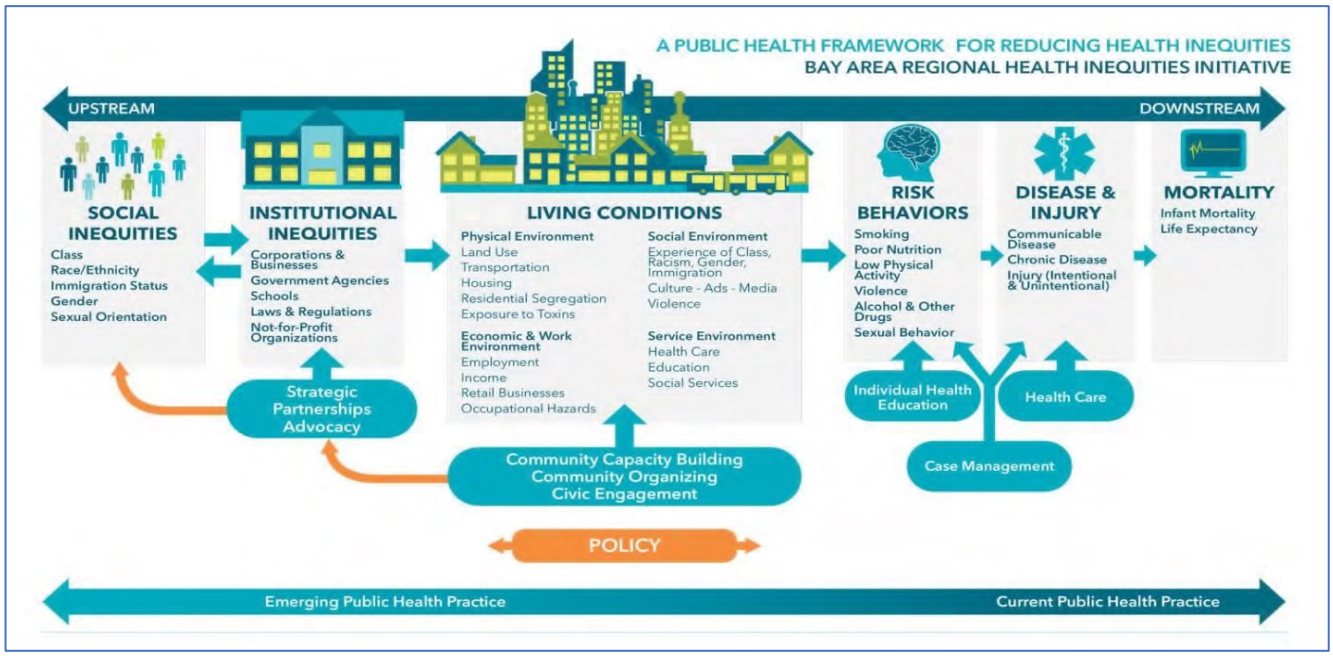
Reducing Cardiovascular Disease Inequities in California: A Partnership Framework for Prevention

Spotlight on Cardiovascular Health: Heart disease and stroke are two of the most common causes of death in California, but many people who are at high risk are not aware that these conditions can be prevented and treated. High blood pressure is one of the leading causes of heart disease and stroke. While heart disease rates and stroke mortality rates are declining, racial/ethnic disparities persist. Recent reductions in cardiovascular disease deaths can be attributed to tobacco-control efforts and improved medical treatments. These gains are threatened by the rise in obesity, lack of access to quality health care, and the persistence of social inequalities. Emerging information on the role of the social determinants of health (SDOH) on cardiovascular disease outcomes can inform collaborative approaches to prevention and management.[1]

This fact sheet outlines strategies to prevent cardiovascular disease using the Bay Area Regional Health Inequities Initiative (BARHII) model in Figure 1. An overview of each approach, possible interventions, and examples of partners working on each part of the model are included. The fact sheet was prepared by the California Chronic Disease Prevention Leadership Project and includes examples from the 2018, 2019, and planned 2020 Public Health and Healthcare Convenings. It is informed by the California Department of Public Health's (CDPH) "The Burden of Chronic Disease, Injury, and Environmental Exposure," California, 2020, Second Edition Report.

Figure 1. A public health framework for achieving healthy communities.



Source: Bay Area Regional Health Inequities Initiative. Framework. 2015; http://barhii.org/framework/. Accessed May 2020.

Social Inequities → Strengthen Social Equity

- **Description:** Social inequalities (e.g., discrimination, racism, classism, and sexism) directly influence cardiovascular disease. The experience of social injustices across the life course, including both individual- and community-level trauma, increases chronic stress that contributes to higher risk of cardiovascular disease.[2]
- **Opportunity:** Institutions can implement leadership and staff training on racial and social equity to shift social narratives to influence downstream decisions (e.g., SDOH) for equity.
- **Spotlight on:**
    - Communities Lifting Communities is a hospital and public health partnership in Southern California to reduce health disparities. The intervention includes governance and leadership training on racial equity, as well reviewing data on disparities and selecting a regional intervention – improving African American birth outcomes.[3]

Institutional Inequities → Transform Institutions for Equity

- **Description:** The distribution of resources and power in public and private institutions directly impacts health. Disinvestment in certain communities, as well as lack of representation, sets up unhealthy living conditions and poverty. Communities with a high concentration of poverty are often where racial and ethnic minorities live. Chronic stress from poverty is associated with higher rates of heart disease.[4]
- **Opportunity:** Institutions can utilize hiring, budget, and procurement practices that advance opportunity for all.
- **Spotlight on:**
    - The State Capitol Collaborative on Race and Equity (formerly GARE Capitol Cohort) supports cohorts of governmental leaders in California who are using tools to integrate consideration of racial equity in policies, practices, hiring, and budgets. One agency – the Strategic Growth Council – has changed their hiring, contracting, and programming practices to improve racial equity.[5]

Living Conditions → Improve Places Where We Live, Learn, Work and Play

- **Description:** Unhealthy living environments (e.g., lack of access to physical activity or healthy foods) are not conducive to healthy behaviors. Unemployment and job insecurity increase high blood pressure rates and mortality.[6] Social isolation is linked to cardiovascular disease.[7] Improving the places where we live, work, and play supports heart health.[8]
- **Opportunity:** Health in All Policies is an approach that incorporates health considerations into policy decisions - including housing and job security, land use, and education. Health systems can be economic drivers for place-based investment and drivers for social change.

- **Spotlight on:**
  - Partnership HealthPlan is a nonprofit health plan in 14 California counties that incorporated social determinants of health into their work. They reinvested their profits back into the community, releasing $25 million in grants to address critical housing needs impacting health and healthcare costs for their members.[9]
  - BARHII is working regionally with health systems, linking public health departments and the hospital and clinic sector to address critical housing needs in the Bay Area. Health departments produced a Housing Brief with three impact strategies and shared with health systems to invest in housing solutions. They are advancing a Community Land Trust to enable low income people to purchase property.[10]
  - Inland Empire Health Plan (IEHP) adopted the Pathways to Population Health Framework for a housing initiative to address the high rate of homelessness in Riverside and San Bernardino. IEHP secured $10 million annually for permanent supportive housing. [11]

Risk Behaviors → Reduce Risk Factors

- **Description:** Risk behaviors such as tobacco and substance use, poor diet, and lack of physical activity increase the risk for overweight/obesity and type 2 diabetes. These risk behaviors contribute to preventable cardiovascular disease.[12]
- **Opportunity:** Institutions can advance policies, systems, and environmental improvements to reduce cardiovascular risk factors.
- **Spotlight on:**
  - **Madera Hospital Farmers' Market and Smoke-Free Campus:** Madera Community Hospital partnered with the Madera Public Health Department to implement a smoke-free campus and establish a farmers' market at the hospital to increase healthy food access.[13]
  - **San Joaquin's Park Activation Partnership:** San Joaquin Public Health Services' partnered with Kaiser Permanente and other delivery systems in San Joaquin County to develop a joint Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). They identified one priority health need to jointly fund: park activation and beautification in priority neighborhoods to encourage physical activity.[14]

Disease → Mitigate and Manage Disease

- **Description:** Increasing detection of high blood pressure and high cholesterol as well as improving treatment and management of diabetes and cardiovascular disease can reduce preventable hospitalizations and mortality. Not enough Californians receive clinical preventive services.[15]

- **Opportunity:** Public health and healthcare can partner on case management and care coordination, including preventive clinical services, comprehensive medication management, and disease self-management.

- **Spotlight on:**
  - California Right Meds Collaborative - Comprehensive Medication Management (CMM) Pilot Projects: CMM is an evidence-based, physician approved, pharmacist-led, preventive clinical service ensuring optimal use of medications to improve health outcomes for high-risk patients while reducing health care costs. CMM Pilot projects in Southern California are a collaboration between Los Angeles Care and Inland Empire Health Plans, Schools of Pharmacy and Community Pharmacies.

Mortality → Improve life expectancy

- **Description:** The three strongest predictors of life expectancy are race/ethnicity, place of residence, and educational attainment.[16] Implementing collaborative, cross-sector strategies across the framework can address the health disparities that lead to differences in life expectancy.
- **Opportunity:** Collaborate on data projects to assess the effectiveness of interventions across the life course and add to the evidence base.
- **Spotlight on:**
  - The California Healthy Places Index is a tool that connects population health data with policy actions. The tool includes life expectancy and other indicators. Local health departments and health systems across California are using this tool to inform policy decisions, investments, and the potential to expand to assess communities over time.[17]

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Endnotes:

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