Disparities in Cardiovascular Disease and Diabetes in California

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Right Care Initiative Meeting

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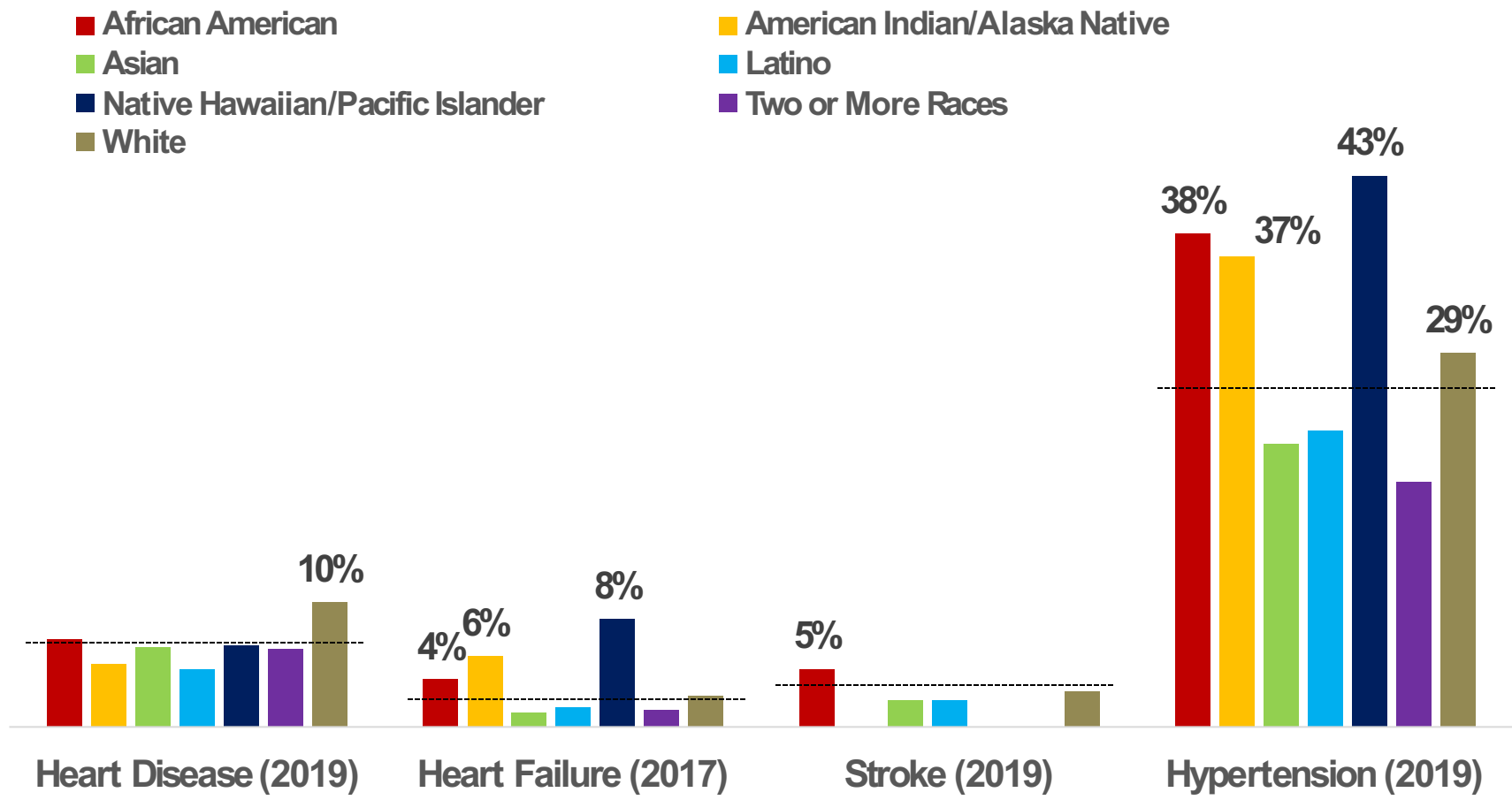
Cardiovascular Disease in California

- 12 million Californians are affected by cardiovascular disease (CVD).
- The most common forms of CVD are:
  - Heart Disease (HD),
  - Heart Failure (HF),
  - Hypertension (HTN), and
  - Stroke.

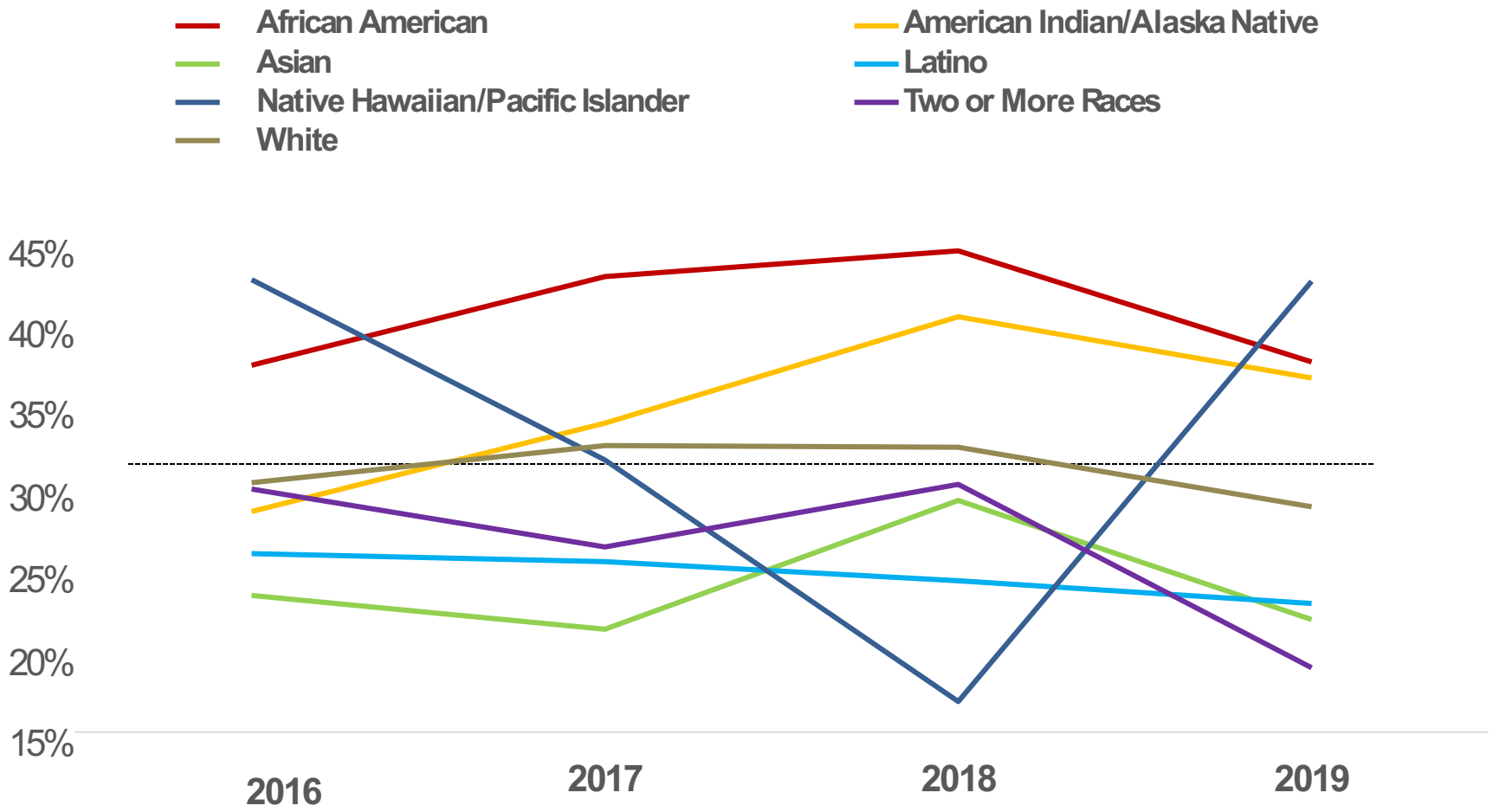
Data Source: AskCHIS 2020..

Prevalence of the Common Forms of CVD by Race/Ethnicity



Data Source: AskCHIS 2017 and 2019 and BRFSS, 2019 data

Prevalence of Hypertension by Race/Ethnicity, 2016-2019



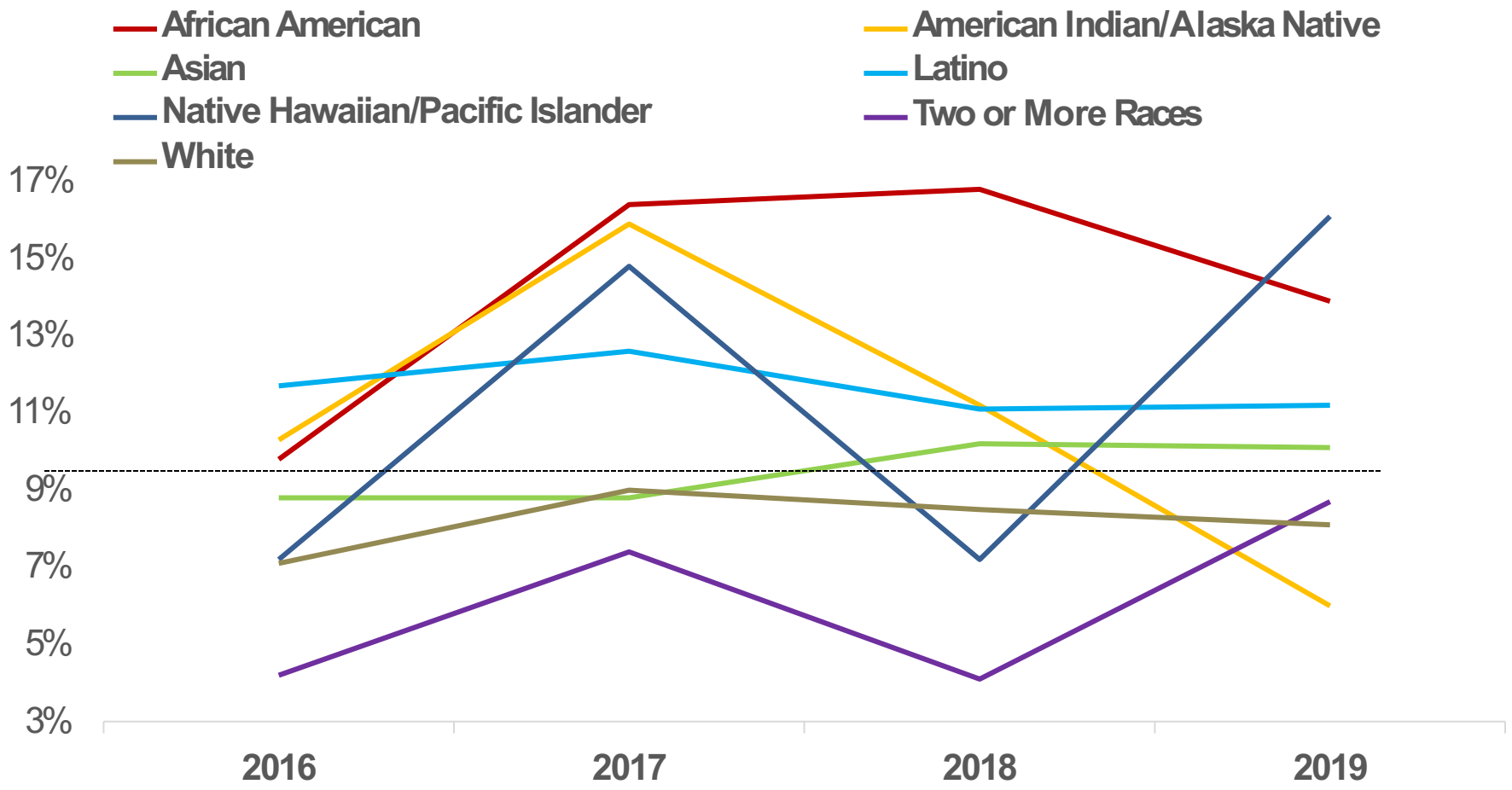
Data Source: AskCHIS 2016-2019 data.

Diabetes in California

- 3 million Californians are affected by diabetes.
- The most common forms of diabetes are:
  - Type 1 and
  - Type 2

Data Source: AskCHIS 2018. Last Accessed on May 21, 2020.

Prevalence of Diabetes by Race/Ethnicity, 2016-2019



Data Source: AskCHIS 2016-2019 data.

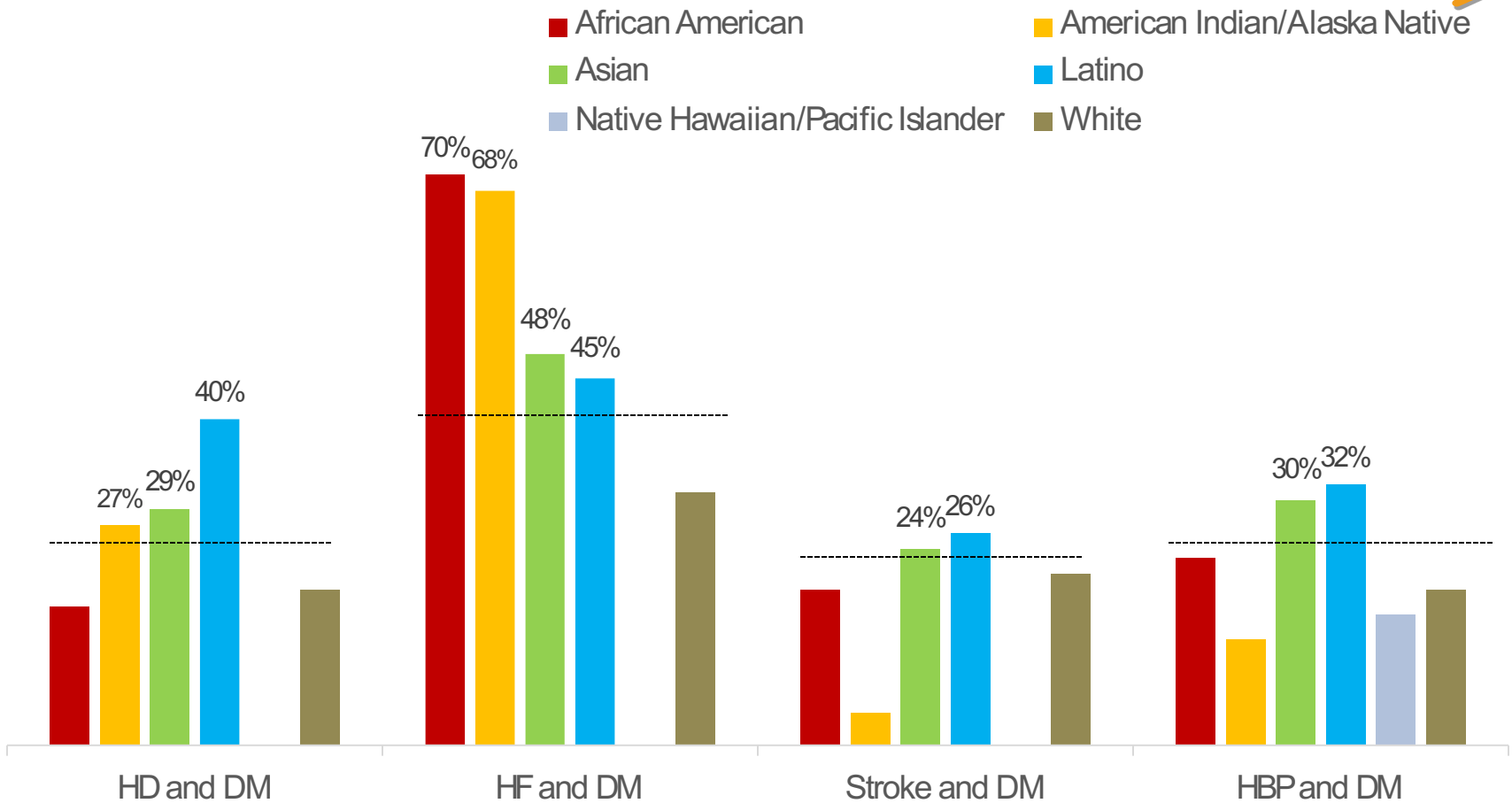
Diagnosed with CVD and Diabetes

- 1 in 4 adults diagnosed with Heart Disease, Stroke, or High Blood Pressure also reported being diagnosed with Diabetes.

- 1 in 2.5 adults diagnosed with Heart Failure also reported being diagnosed with Diabetes.

Data Source: CHIS Data 2012,17, and 19.

Diagnosed with CVD and Diabetes by Race/Ethnicity



Data Source: AskCHIS 2012, 17, and 19 data.

CA Leading Causes of Death, 2019

Disease or Condition	2019 Rank & Number of Deaths	2020 Rank & Number of Deaths	2021 Rank & Number of Deaths
Heart Disease	Rank: 1 & 62,467	Rank: 2 & 65,942	Rank: 2 & 31,823
Cancer	Rank: 2 & 59,512	Rank: 3 & 59,472	Rank: 3 & 28,611
Alzheimer's Disease	Rank: 3 & 16,860	Rank: 4 & 18,708	Rank: 5 & 8,728
Stroke	Rank: 4 & 16,852	Rank: 6 & 17,768	Rank: 4 & 9,065
Accidents	Rank: 5 & 15,196	Rank: 5 & 17,834	Rank: 6 & 7,199
Chronic Obstructive Pulmonary Disease	Rank: 6 & 13,094	Rank: 7 & 12,830	Rank: 8 & 5,579
Diabetes	Rank: 7 & 9,859	Rank: 8 & 11,594	Rank: 7 & 5,756
Influenza/Pneumonia	Rank: 8 & 5,672	Rank: 11 & 6,005	Rank: 11 & 2,284
Hypertension	Rank: 9 & 5,600	Rank: 10 & 6,057	Rank: 10 & 3,203
Chronic Liver Disease/Cirrhosis	Rank: 10 & 5,576	Rank: 9 & 6,120	Rank: 9 & 3,378

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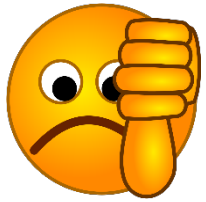
Data Source: California Vital Statistics Death Master File, 2019-2021

Leading Causes of Death

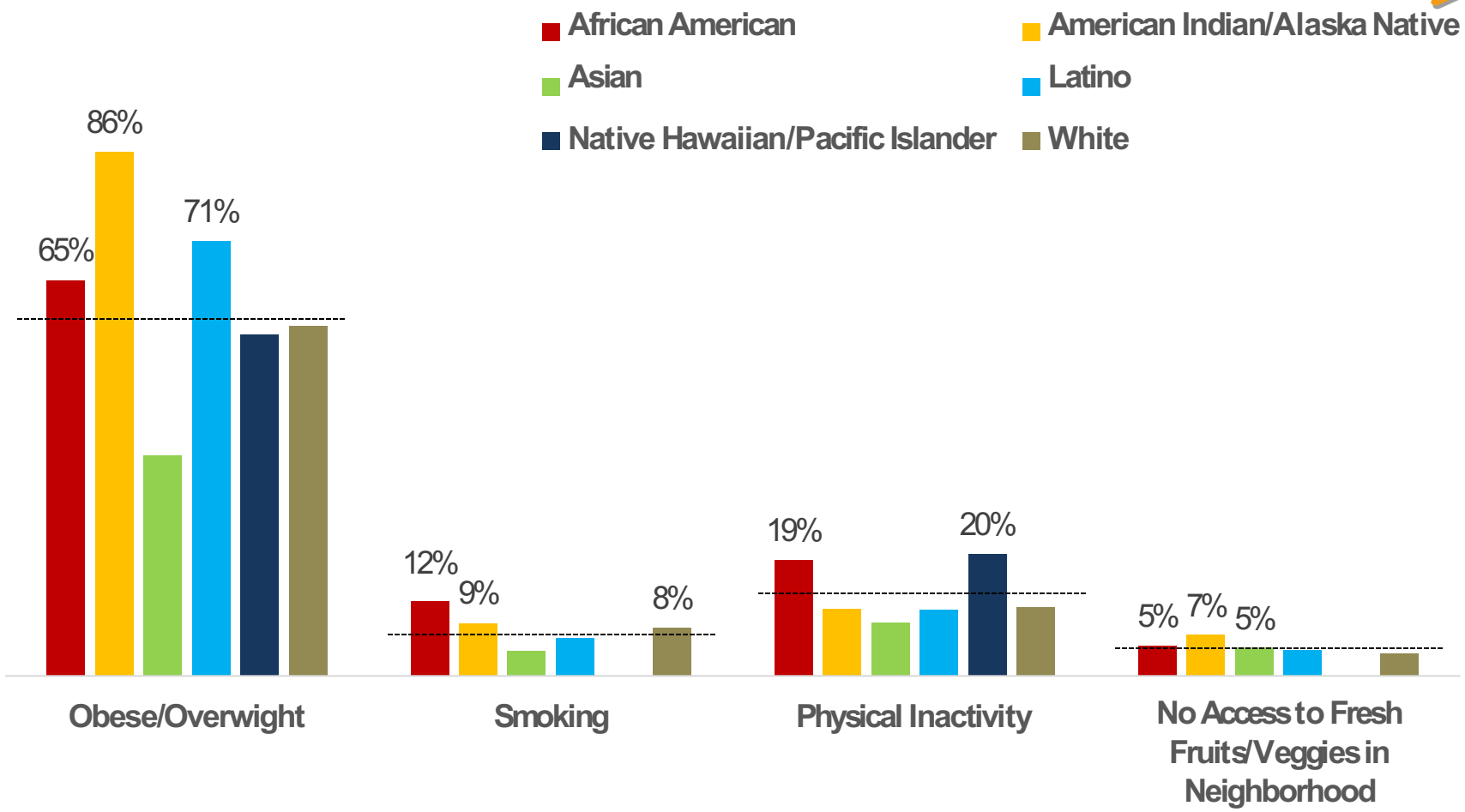
- California met the *HP 2020* HDS-2 objective to reduce heart disease deaths to no more than 103 age-adjusted deaths per 100,000 population.



- California did not meet the *HP 2020* HDS-3 objective to reduce stroke deaths to no more than 34.8 age-adjusted deaths per 100,000.

County Health Statistics, 2019 and Healthy People 2020.

CVD and Diabetes Associated Risk Factors by Race/Ethnicity



Data Source: AskCHIS 2018 and 19 data. Last accessed on August 15, 2021.

Cost of CVD and Diabetes

- In 2018, CVD costs California an estimated $51.9 Billion and Diabetes costs $18.9 Billion.
  - These costs are specific to direct (health care costs)and indirect (lost productivity and life years) costs.

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Economic Burden of Chronic Disease in California, 2018

Addressing CVD and Diabetes Disparities Through Programs

Prevention Forward (PF) is the five-year Centers for Disease Control and Prevention grant the California Department of Public Health Chronic Disease Control Branch received to increase prevention and management of diabetes, prediabetes, hypertension, stroke, and high blood cholesterol.

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PF Objectives to Address the Burden of CVD

Objective 1: Assess and increase use of health care reporting systems to iden report standard clinical quality measures, and/or refer patients with chronic con nationally recognized lifestyle change programs;

Objective 2: Identify policies and procedures within the organization to identify and prevent chronic conditions; and

Objective 3: Assess use of team-based models to manage, monitor, and refe patients with chronic conditions to nationally recognized lifestyle change prograr

Objective 1: Assess and increase use of health care reporting systems to identify, report standard clinical quality measures, and/or refer patients with chronic conditions to nationally recognized lifestyle change programs.

- PF is linking partner clinics, hospitals, and pharmacies to electronic health systems technical assistance to ensure patients with chronic conditions are:
  - Diagnosed (identified),
  - Referred to lifestyle change programs within their community, and
  - Receive standard clinical quality care.

- PF is promoting telehealth capacity to link patients to health care services to reduce delayed care.

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Objective 2: Identify policies and procedures within the organization to identify, manage, and prevent chronic conditions.

- PF is promoting the patient care process, which includes Comprehensive Medication Management (CMM)/Medication Therapy Management to manage CVD and Diabetes.
- PF is promoting and hosting health education and self-management of CVD and Diabetes webinars.
- PF is promoting adoption and implementation of team-based care approaches with the inclusion of non-physician team members.

Objective 3: Assess use of team-based models to manage, monitor, and refer patients with chronic conditions to nationally recognized lifestyle change programs.

- PF is promoting and sharing information about CMM, Collaborative Practice Agreements, and adoption of team-based models.

- PF staff is working to increase equity capacity with Community Health Workers and providers to promote improved awareness and treatment of patients with CVD and Diabetes.

- PF staff is hosting webinars on lifestyle modification/referral topic area regarding self-measured blood pressure monitoring training and diabetes management.

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Prevention Forward Surveillance

- PF monitors treatment, management, referrals, and engagement of non-physician team members to reduce CVD burden and/or negative health outcomes from being diagnosed with CVD and/or diabetes.
- Next steps are to implement evidence-based interventions in PF partner clinics, hospitals, and pharmacies then monitor change in screening, treating, referring patients with CVD and/ore diabetes to lifestyle change programs, and medication management. PF will also monitor change in communication between team members and use of CMM and Collaborative Practice Agreements.

Addressing CVD Disparities Through Programs

Cardiovascular Disease Prevention Program is a Centers for Disease Control and Prevention Block grant the California Department of Public Health Chronic Disease Control Branch received to increase hypertension control.

Cardiovascular Disease Prevention Program

- Hosts Healthy Hearts California Meetings.
- Partners with Universities, Pharmacists, and Health Systems for stroke prevention and management through team-based approaches including CMM.
- Will update the California Master Plan for Heart Disease and Stroke.

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Questions???

Contact Information

For additional comments and/or questions pertaining to this presentation please contact:

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