

Building Heart-Healthy Communities: *Local Health Departments and Partners in Action*



Cardiovascular disease remains the leading cause of death in the United States, with hypertension as a major contributing factor. Although effective prevention and control strategies exist, barriers such as limited access to healthcare, nutritious foods and ongoing self-management resources make it difficult for many people to maintain heart-healthy habits. Local health departments and their partners play a critical role in addressing these challenges by implementing community-based and system-level approaches that make prevention more accessible, coordinated, and sustainable.

This compendium highlights five examples from the field that demonstrate how health departments and partner organizations are advancing cardiovascular disease prevention and control through innovative, locally tailored strategies. Collectively, these stories illustrate a range of evidence-based approaches, from blood pressure monitoring and clinical quality improvement to food access and community engagement – all designed to help residents detect risk early, manage chronic conditions, and adopt heart-healthy behaviors.



Across these examples, several common themes emerge:

- **Hypertension control as a cornerstone of prevention.** Each initiative prioritizes blood pressure management through screenings, home monitoring, and self-measured blood pressure programs that empower residents to track and manage their health.
- **Community accessibility and trusted spaces.** Programs intentionally meet people where they are, whether at libraries, senior centers, schools, clinics, or community farms – reducing barriers to care and reaching those less likely to connect with traditional healthcare systems.
- **Integration of social and clinical support.** Addressing social drivers of health, such as food access and transportation, strengthens cardiovascular prevention efforts and helps improve overall health outcomes. Initiatives like Little Rivers Health Care’s Food Farmacy and Los Angeles County’s Produce Prescription Program show how aligning nutrition, healthcare, and social resources can improve outcomes, while the county’s integration of social health tools within Federally Qualified Health Centers demonstrates how clinical systems can better respond to patient needs.
- **Education, follow-up, and sustained engagement.** Consistent health education, coaching, and follow-up, such as those seen in Porter County’s community partnership and Chatham Health District’s self-management workshops, help residents build confidence, adopt healthier habits, and sustain long-term behavior change.
- **Partnerships as a catalyst for impact.** Each effort underscores the importance of collaboration across sectors. From local libraries and YMCAs to academic institutions, food access networks, and public health agencies, these partnerships enhance reach, leverage shared resources, and strengthen program sustainability.

Individually, each story reflects unique community assets and priorities.

Chatham Health District (CT) expands hypertension screening and education through home blood pressure monitors and evidence-based self-management programs.

Little Rivers Health Care (VT) redefines clinical care by prescribing access to nutritious food as part of chronic disease management.

Porter County Health Department (IN) demonstrates how trusted community spaces and consistent education can foster participation and lasting behavior change.

Los Angeles County Department of Public Health (CA) advances system-level improvements by supporting Federally Qualified Health Centers in implementing data-driven, team-based hypertension control strategies and piloting a Produce Prescription Program that connects patients experiencing food insecurity with affordable, fresh fruits and vegetables to support cardiometabolic health.

Together, these stories offer replicable models for strengthening cardiovascular disease prevention and promoting heart health in communities of all sizes. By integrating clinical care with community partnerships, addressing social needs, and empowering individuals to manage their health, these initiatives demonstrate the broad potential of local action in building heart-healthy communities.



Chatham Health District (East Hampton, CT) – *Community Screenings Drive Blood Pressure Awareness*



With funding from the Preventive Health and Health Services Block Grant, Chatham Health District (CHD) expanded its cardiovascular disease prevention efforts by offering free monthly blood pressure clinics, community education presentations, and Stanford University’s evidence-based Chronic Disease Self-Management and Diabetes Self-Management Workshops at senior centers and libraries across the six towns it serves.

Challenge

Cardiovascular disease is one of the leading causes of death in Chatham County. In the six towns CHD serves, residents, particularly older adults, face several barriers to good health, including limited

access to healthcare, transportation barriers, and a lack of ongoing health education. These factors contribute to late diagnoses, unmanaged chronic conditions, and higher emergency care use.

Many residents also live with chronic conditions such as diabetes, which further increases cardiovascular risk. Prior to program implementation, there were limited local resources for chronic disease education, early intervention, or self-management support. CHD identified a need for accessible, evidence-based community programs that promote prevention, early detection, and long-term self-care for residents at risk of, or living with, cardiovascular and related chronic conditions.



Solution

With funding from the Preventive Health and Health Services Block Grant, CHD implemented a multi-pronged, community-centered strategy to address cardiovascular disease and related chronic health issues.

Key components include:

- **Free Monthly Blood Pressure Clinics**
Held across six towns to detect and manage hypertension. Funding also supports distributing home blood pressure monitors so residents can track readings at home.
- **Evidence-Based Workshops**
Two CHD-trained facilitators deliver Stanford University's six-week Chronic Disease Self-Management Program and Diabetes Self-Management Program, empowering participants with tools for healthy eating, physical activity, medication adherence, and symptom monitoring.
- **Community Health Education**
Monthly presentations at senior centers and libraries on topics such as heart health, nutrition, physical activity, and diabetes awareness foster ongoing engagement and awareness.

Led by CHD's Public Health Nurse and the Prevention Program Coordinator, and hosted in easily accessible community spaces, these programs follow CDC-recommended best practices for community-based prevention. Partnerships with local governments, libraries, senior centers, and community organizations ensured strong support and attendance. These efforts collectively reduce barriers to care while building knowledge, skills, and confidence among residents to self-manage

250+
blood pressure screenings completed

85%
increased confidence in managing symptoms,
medication, and provider communication

their conditions.

Results

- To date, CHD's cardiovascular health initiative has reached over 500 community members through clinics, workshops, and education sessions.
- Over 250 blood pressure screenings completed and 125 home monitors distributed.
- One hypertensive crisis was detected and treated, potentially saving a life.
- Over 50 residents completed the Chronic Disease and Diabetes Self-Management Programs, with 85% reporting increased confidence in managing their health.
- Participants report improved physical activity, healthier eating, and fewer hospital visits.
- Monthly presentations draw 10-20 attendees, keeping topics relevant based on community feedback.

The integration of clinical screenings, education, and evidence-based programming is helping residents build sustainable habits and reduce reliance on acute care services, improving long-term health outcomes district-wide.

Lessons Learned

One of the most valuable lessons learned is the effectiveness of combining direct services, like screenings. With ongoing education and peer-led support. Residents were more likely to make lasting behavior changes when they felt supported and informed.

The self-management workshops are effective but require sustained outreach to encourage participation and retention, especially among older adults hesitant about multi-week commitments. Monthly clinics and educational sessions helped build trust, creating opportunities for deeper engagement and more meaningful outcomes. Having consistent staff presence and culturally appropriate materials helped ensure accessibility for all residents.

Moving forward, CHD plans to expand outreach through digital platforms and physician referrals, offer workshops in more locations, and explore partnerships with local pharmacies and housing sites. This comprehensive, scalable approach can be replicated in other communities, especially those with limited clinical access by combining evidence-based programs, low-barrier screenings, and trusted community education.

More information

To learn more about Chatham Health District's chronic disease and cardiovascular prevention programs, visit <https://www.chathamhealth.org/community-health>.

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Porter County Health Department (Valparaiso, IN) – *Trusted Spaces Expand Access to Heart Health Resources*



The Porter County Health Department addresses cardiovascular health through innovative community partnerships. Initiatives such as the Reducing Undiagnosed Diabetes Initiative (RUDI), *Libraries with Heart* blood pressure monitoring kits, the YMCA's Blood Pressure Self-Monitoring Program, and youth screenings in partnership with the Zac Mago Foundation empower residents to detect risks early and adopt healthier habits. These efforts improve long-term heart health outcomes across Porter County.

Challenge

Cardiovascular disease remains the leading cause of death in Indiana, disproportionately affecting low-income and underserved populations. Rising rates of hypertension, obesity, and type 2 diabetes contribute significantly to this burden.

Many residents remain undiagnosed or unaware of their cardiovascular risk, limiting opportunities for timely treatment and prevention.

Traditional healthcare systems often miss individuals without regular access to providers. Late detection can lead to severe disease progression, hospitalizations, and costly interventions. Older adults, low-income residents, and those in rural areas face the highest barriers to care.

Before these initiatives, few community-based resources existed to help residents self-monitor and manage health outside clinical settings. Prevention efforts were fragmented, and practical support for managing conditions like high blood pressure and prediabetes was limited.



Recognizing these gaps, the Porter County Health Department partnered with local organizations including the Zac Mago Foundation, Powers Health, local libraries, the American Heart Association (AHA), and the local YMCA to create accessible, evidence-based programs that promote early detection, self-monitoring, and healthier daily choices for all residents, including youth.

Solution

In partnership with Powers Health, the Porter County Health Department implemented prevention-focused strategies to reduce cardiovascular disease and related complications. Central to these efforts is the Reducing Undiagnosed Diabetes Initiative (RUDI), which identifies residents at risk for prediabetes and promotes early intervention through screening and lifestyle support.

To expand access, the *Libraries with Heart* program allows residents to borrow blood pressure kits from county libraries to track and manage their cardiovascular health at home.

In collaboration with the Portage YMCA, the Blood Pressure Self-Monitoring Program, supported by the AHA's Heart Safe initiative, empowers adults with hypertension to monitor readings, receive coaching, and adopt healthier habits.

Additional community screenings through the Zac Mago Foundation provide youth heart screenings in schools and at health fairs across Porter County, detecting early signs of cardiovascular risk and fostering lifelong heart health awareness.

Together, these initiatives bring evidence-based programs in trusted community spaces, such as libraries, schools, community centers, and the YMCA. Strategic partnerships expand reach credibility, helping both adults and youth gain tools they need for early detection, self-management, and healthier lifestyle choices.

Results

These initiatives have led to measurable improvements in awareness, self-monitoring, and engagement in heart-healthy behaviors.

Libraries with Heart distributed more than 150 blood pressure kits, with patrons reporting increased confidence and early detection of high readings.

At the Portage YMCA, participants in the Blood Pressure Self-Monitoring Program showed consistent blood pressure reductions over four months, along with improved diet, increased physical activity, and better medication adherence.

The RUDI program identified previously undiagnosed prediabetes cases, connecting residents to follow-up care and reducing the risk of developing type 2 diabetes.

Through the Zac Mago Foundation, hundreds of youth received heart screenings at schools and community events, leading to early detection, education, and referrals for families.

Collectively, these efforts reached hundreds of residents and youth, improving awareness, early detection, and healthy behavior adoption. Participant surveys, program reports, and pre-post evaluations show short-term gains and long-term potential: reduced disease progression, improved health knowledge, and healthcare costs.

Accessibility Matters

Locating programs in familiar spaces
increases participation

Lessons Learned

Key lessons emerged from implementing these cardiovascular initiatives:

- **Accessibility matters.** Locating blood pressure kits in libraries and offering school-based screenings reached people less likely to engage with traditional healthcare. Familiar, trusted spaces boosted participation.
- **Partnerships amplify impact.** Collaborating with the YMCA, Powers Health, the Zac Mago Foundation, libraries, and AHA-supported programs provided resources, structure, and credibility. Strong relationships were essential to success.
- **Education and follow-up sustain behavior change.** Residents benefited most when tools like blood pressure kits or screenings were paired with instructions, coaching, and encouragement to seek care.

Areas for improvement include expanding outreach to raise awareness and strengthening evaluation efforts to capture long-term outcomes.

Overall, this initiative demonstrates that community-based cardiovascular prevention strategies are effective, replicable, and adaptable. Embedding programs in trusted spaces, forming partnerships, and prioritizing accessibility can improve cardiovascular health outcomes for both adults and youth.

More information

To learn more about Porter County's community health programs, visit <https://www.in.gov/localhealth/portercounty/>

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Little Rivers Health Care and White River Junction District LHD (White River Junction, VT) – *Food Farmacy Links Nutrition and Heart Health*



Traditional models of hypertension management are not working, and hypertension remains a top priority for most hospitals and clinics. Little Rivers Health Care (LRHC) is redefining the care model to include social drivers of health by focusing on hunger. Through its Food Farmacy program, LRHC addresses food insecurity as a vital sign to improve cardiovascular outcomes.

Challenge

It is difficult to move the needle on cardiovascular disease risk and hypertension control. Clinical staff are overburdened and lack the resources and personnel to create system-level change. In 2020, 27% of adults in the White River Junction health district had a hypertension

diagnosis (VT BRFSS, 2019 & 2020), and cardiovascular disease risk was significantly higher than the state average (VT BRFSS, 2017, 2019, 2021).

Households with low incomes and those experiencing poor mental health also carried a significantly higher cardiovascular risk compared to Vermont overall (VT BRFSS, 2017, 2019, 2021). These findings highlighted the need for a more holistic approach to patient care.

However, a persistent challenge was breaking down silos and aligning the expertise of medicine, informatics and community partners to create meaningful, sustainable change.



Solution

LRHC's innovative model integrates food access, a key social driver of health, into clinical care, recognizing that prescriptions for fresh, local produce can be powerful tools in managing chronic conditions. The Food Farmacy serves patients with diabetes, hypertension or cardiovascular disease risk who also face barriers to accessing nutritious food.

Over five years, LRHC partnered with Bi-State Primary Care Association, Dartmouth's Center for Advancing Rural Health Equity, the Public Health Council of the Upper Valley and the Vermont Department of Health to secure funding and strategic support. The clinic implemented hunger-as-a-vital-sign screening, care coordinator workflows for social referrals, data collection systems, local produce distribution, and patient experience evaluation.

The program's network is diverse: Willing Hands, the VT Food Bank, Root 5 Farm and Hannaford contribute donations, food drives, and Community Supported Agriculture (CSAs). Beyond food, TriValley Transit provides bus routes to clinics on distribution days; National Honor Society volunteers assist operations; MyHealthyVT delivers health education; and the American Heart Association supplies nutrition guides, home health materials and blood pressure cuffs available for self-monitoring at local libraries.

65%

Hypertension control rate among participating patients



Results

At the outset, LRHC focused on improving falsely low positive screening rates for hunger as a vital sign, recognizing that how the screener was worded and implemented affected data accuracy. Through multiple quality improvement cycles, the percentage of patients screening positive increased, reflecting the need in surrounding counties.

With more accurate data, LRHC expanded the program over five years to meet patient needs and track BMI, HbA1c, cholesterol, systolic blood pressure, and the amount of produce distributed. By July 2024, the program had distributed 68,669 pounds of fresh produce. Four mini-pantries stocked with shelf-stable foods were also established in each clinic, available to all patients.

As of September 2025, the program enrolled 102 participants and distributed 750-1000lbs of produce weekly from Willing Hands alone. Participants achieved statistically significant improvements in BMI and systolic blood pressure, with an overall hypertension control of 65% among the patient population.

Lessons Learned

This program is both replicable and scalable across settings and populations. Following initial success, LRHC expanded eligibility to include pregnant and postpartum patients (within six months of delivery). Other nutritionally responsive conditions are also expected to benefit from the Food Farmacy model.

A key success factor has been collective action among diverse partners working toward a shared agenda. Each brings unique assets, such as funding, leadership, strategy, produce, data management, or volunteer support to strengthen the program. Because of the diversified funding sources, the initiative is more sustainable and less vulnerable to shifts in any single funding stream.

The strong cohesion among partners at the local, regional and national levels has been central to the program's long-term success and sustainability.

More information

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Los Angeles County Department of Public Health (CA) – Prescribing Produce to Reduce Cardiometabolic Risks Among FQHC Patients



The Los Angeles County Department of Public Health implemented a produce prescription program in 2021 to manage patient cardiometabolic risks at 9 Federally Qualified Health Center clinics in Los Angeles County. This Food as Medicine strategy sought to facilitate conditions and supports that are necessary to reduce cardiovascular disease and maintain optimal health for all.

Challenge

Among Los Angeles County's nearly 10 million residents, 28% of adults have hypertension, 33% have high cholesterol, 11% have diabetes, and 44% have prediabetes; most of these conditions are attributed to poor diet. Because they are linked to cardiovascular disease (CVD), controlling these risk factors is a critical intervention for reducing CVD events and driving down their associated healthcare costs and utilization, including hospital admissions, prescriptions, and doctor's visits.

While the COVID-19 public health emergency ended in 2023, food insecurity did not. One in four households remained food insecure afterwards. Data suggest that adults living in food insecure households are particularly susceptible to developing diet-related chronic conditions, including heart disease, stroke, and diabetes. In response to this health/social need, Food as Medicine strategies emerged as popular interventions for addressing cardiometabolic risks or complications associated with these conditions. These strategies provide nutrient-dense foods to prevent, treat and even reverse diet-related chronic disease within healthcare settings.

They include medically tailored meals, medically tailored groceries, food pharmacies, and the produce prescription program (PPR). The PPR, in particular, is a type of nutrition incentive program that increases access to fresh fruits and vegetables by subsidizing the cost of produce for individuals/households experiencing food insecurity.



Solution

With funding from the United States Department of Agriculture, National Institute of Food and Agriculture, the Los Angeles County Department of Public Health partnered with three Federally Qualified Health Center (FQHC) systems to implement a PPR in nine healthcare clinic sites across Los Angeles County, California. The three partner systems included Northeast Valley Health Corporation, Venice Family Clinic, and Asian Pacific Health Care Venture, Inc.

The PPR's goal is to increase access to fresh fruits and vegetables for patients who are diagnosed with diabetes or prediabetes and experiencing food insecurity. Healthcare providers "prescribed" produce vouchers to eligible patients in the form of debit cards (each patient received \$40/month for six months) that could be redeemed exclusively for fresh fruits and vegetables at participating supermarkets and large grocery stores. A standardized program infrastructure was established at the FQHCs to track changes in health outcomes using self-administered surveys, blood pressure measurements, and glycated hemoglobin (HbA1c) documented in the electronic health record.

Food security improved by

18%

Systolic blood pressure dropped

1.28 points

Diastolic blood pressure dropped

1.64 points

Results

The PPR enrolled over 2,400 patients across the nine healthcare clinic sites, with participants redeeming over \$400,000 (70% of the total disbursements) at participating supermarkets and grocery stores to purchase fresh fruits and vegetables. The total estimated economic impact of this PPR intervention is estimated to be approximately \$686,000, reflecting the program's contributions to the local and regional food systems in Los Angeles County.

The PPR showed other positive patient improvements as well, including for fruit and vegetable consumption, food security, and cardiometabolic measures (e.g., hemoglobin A1c, blood pressure). For example, self-reported fruit and vegetable consumption increased by 0.18 cups (2.50 cups to 2.68 cups). Self-reported food security status increased by 18.06% at program completion. Participants' HbA1c measurements, as tracked in the electronic health record, decreased by 0.37% (8.05% to 7.68%). Average systolic blood pressure decreased by 1.28 points (131.04 to 129.76) and diastolic blood pressure by 1.64 points (79.24 to 77.60). Patient participants lauded their experiences with the program. One stated: *"My blood sugar was very high before and now, lately, it is lower because I eat healthier. The program helped me a lot."* Another shared they now eat more fruits like apples after completing the program.



Lessons Learned

A key factor in the successful implementation of the PPR has been the preexisting partnerships between the Public Health department and the FQHCs. These partnerships were originally established through the Supplemental Nutrition Assistance Program Education initiative in Los Angeles County; the PPR experience has since strengthened these collaborations. Collectively, these partnerships prepared and fostered the clinics' capacity to incorporate or augment clinic workflows so sites could better screen for food insecurity and refer eligible patients to the PPR and other services. Key lessons learned from the implementation also included: (i) the substantial amount of time clinic staff spent enrolling patients into the PPR, and (ii) how alignment of SNAP-Ed resources helped advance this produce prescription work by providing overlapping structure and extra support. Another lesson was how frequently the \$40 incentive amount fell short for program participants, since they often shared food with their families. Future program designs should consider local costs of food to better align PPR incentive amounts with household needs. Additionally, expanding partnerships to farmers' markets and/or local farms that can provide more affordable, nutrient dense food options, could serve as another effective strategy for mitigating the produce affordability barrier that enrollees often faced during program participation.

More information

To learn more about LA County's prescription program, visit <http://publichealth.lacounty.gov/nut/programs/produce-prescriptions.htm>

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Los Angeles County Department of Public Health (CA) – *Strengthening Hypertension Control Through Clinic Partnerships*



In 2024, the Los Angeles County Department of Public Health (LACDPH) partnered with a regional association of community clinics to support the implementation of quality improvement projects within Federally Qualified Health Centers (FQHCs). These projects promote hypertension control by optimizing health information technology usage, promoting team-based care, and addressing several social drivers of health.

Challenge

Cardiovascular disease is the leading cause of death, both nationally and in Los Angeles County (LAC), but managing health conditions, such as hypertension, can significantly reduce its risk.¹ Hypertension is highly prevalent and does not impact all populations equally. For example, while the overall prevalence of hypertension in LAC

is 26%, it is substantially higher (45%) among residents living <200% of the Federal Poverty Level.² These differences by socioeconomic status are associated with a multitude of factors which influence health, including a poor diet, lack of exercise, lower educational attainment, higher unemployment, increased stress, higher alcohol and tobacco consumption, unmet social needs, and insufficient access to healthcare.³

Communities that are disproportionately impacted by these conditions are more vulnerable to developing or having uncontrolled hypertension and thus, at increased risk of cardiovascular disease. In order to meet the needs of these communities, multidisciplinary cardiovascular health programming that incorporates effective clinical workflows, health education, and social support into clinical care delivery is essential.



Solution

In an effort to address this challenge, LACDPH partnered with the Community Clinic Association of Los Angeles County (CCALAC) to optimize cardiovascular health programming at local FQHCs. CCALAC is a non-profit organization that represents 66 FQHC systems, which operate over 450 primary care sites throughout LAC and serve over 2 million patients annually.⁴ They treat a high proportion of patients who are low-income, medically underserved, and suffer from uncontrolled chronic conditions.

Through their partnership with LACDPH, CCALAC recruited 6 FQHC systems serving communities that have a high prevalence of hypertension to participate in a quality improvement coaching program. Research has shown that quality improvement interventions can be powerful tools for improving the clinical management of hypertension among low-income patients and can inform broader population health management efforts in this setting.⁵ Drawing from this research, CCALAC worked with each FQHC to develop a quality improvement project designed to increase access to both health and social services for patients with hypertension. These projects leverage health information technology (e.g., population health management tools, community resource referral platforms, remote patient monitoring devices, etc.) and reimbursement opportunities under Medi-Cal (California's Medicaid program) to better support patients with complex health and social needs.⁶

Results

With support from LACDPH and CCALAC, the six participating FQHCs have developed project protocols that are tailored to their individual sites and incorporate the key principles of quality improvement. These principles consist of identifying a problem area to address, setting a related target goal for improvement, and developing a feasible action plan that includes a data collection and evaluation component for measuring progress and outcomes. The target goal for improvement across all of these projects is a 5% increase in hypertension control. Sample project activities include:

- Developing workflows for integrating social health tools (e.g., food insecurity screening) into electronic health record systems; these systems also incorporate reimbursable diagnosis coding;
- Partnering with non-profit organizations (e.g., food pantries) and businesses (e.g., Uber or Lyft Health) to increase patient access to social supports and community services, including nutrition and transportation assistance; and
- Incorporating medication management, lifestyle change support, and social services navigation into clinics' self-measured blood pressure monitoring programs.

Additionally, through this program, each FQHC participates in an Affinity Group that provides clinic staff with the opportunity to meet regularly with CCALAC coaches and personnel from other participating FQHCs that are working on similar quality improvement projects.

6 FQHCs

Implemented quality improvement projects to enhance team-based care and address social drivers of health.

Lessons Learned

In the first year of implementation, substantial progress has been made toward achieving project milestones. Although evaluation efforts are ongoing, FQHCs are beginning to see gains in their clinical quality improvement targets. The establishment of the Affinity Groups has proven quite effective in fostering practical peer-to-peer learning. At Affinity Group meetings, strategies for sustainability and collaboration are being discussed. Discussions have already led to an exchange of ideas around leveraging alternate funding sources to integrate multidisciplinary team-based care and health information technology into existing programming and making the business case that these efforts provide a good return on investment. Additionally, participation in Affinity Groups has led to new referral pathways across FQHCs to leverage resources (e.g., dental services) that are not available in all FQHC systems. FQHC staff have lauded the opportunity to learn, not only from quality improvement coaches, but also from their colleagues; this has been invaluable to them.

As FQHCs complete their projects, data gathered during implementation will be evaluated to further determine whether the interventions could be adopted and standardized at a larger level. In future years, additional FQHCs will be recruited into this quality improvement program to increase the effort's reach in LAC.

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More information

To learn more about LA County's community clinic partnership program, visit [Community Clinic Association of Los Angeles County Website](#)

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