

## *Editorial*

### **FRAMING CARDIOVASCULAR HEALTH FOR RURAL POPULATIONS: COMMUNITY, INNOVATION, EVIDENCE-BASED PRACTICE, AND TECHNOLOGY**

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Cardiovascular disease (CVD) is the leading cause of death in the United States. More than twice as many deaths occur due to cardiovascular disease as for all types of cancers combined. Nationally, every year approximately 16 million cases of coronary heart disease are reported (AHRQ, 2005). In 2005 the total cost for all forms of CVD was an astounding \$448.5 billion. Furthermore, CVD is associated with many forms of chronic illness which add to the cost and decrease quality of life (AHRQ, 2005).

For these reason CVD has received much attention in health research and health policy arenas (Krumholz et al., 2009; Peterson et al., 2007; Yusuf, Reddy, & Anand, 2002). Findings from studies indicate an overall reduction of heart disease risk and mortality in the past three decades (AHA, 2005). While the amount of research noted throughout the literature is overwhelming and heart disease mortality has fallen, heart disease continues to be the single largest killer of men and women in the United States with continuing evidence of variations and disparities that are yet unexplained.

Prevention and treatment of heart disease is currently a major health priority. The Agency for Health Care Quality, the Center for Disease Control and Prevention, and the United States Department of Health and Human Services have identified major strategies in the prevention, risk reduction, and treatment of heart disease. Many large national and international health initiatives have been conducted for the purpose of the advancement of these strategies (CDC, 2009; Peterson et al., 2007; AHRQ, 2005; Ricketts, 1999).

Access to quality, evidence-based health care continues to vary across populations. The literature documents inherent variation in cardiovascular health care access as well as adverse cardiovascular outcomes associated with different geographical regions and urbanization levels (Eberhardt et al., 2001; Ricketts, 1999; AHRQ, 2005). Disparities in health care access add to vulnerability and increased risk of heart disease in rural populations as well as excess patterns of cardiovascular mortality and morbidity.

Health care policy and market changes have adversely affected health care in rural America. The rural health environment has felt the impact of hospital closures, loss of community health services, rising cost, and changes in health care delivery and reimbursement systems. As rural communities confront these changes they must also continue to navigate ongoing problems associated with higher poverty rates, a more dispersed, elderly population, fewer doctors, and less access to transportation sources (AHRQ, 2008).

To meet these challenges new approaches to cardiovascular health care for rural communities are needed. The recipe for moving toward cardiovascular health in rural, underserved areas will need to include a focus on innovation and outcomes using evidence-based practice and technology in the spirit of community. Through community empowerment rural populations can solve their own unique cardiovascular health issues through a spirit of inquiry, using creative community partnering and quality health care provided by practitioners who use

the best evidence to guide decisions in practice. Therefore, decreasing cardiovascular mortality and morbidity and improving cardiovascular health will need to be framed within the context of community, innovation, evidence-based practice, and technology.

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