The American Heart Association's Strategic Policy Agenda 2017-20

American Heart Association | American Stroke Association

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Introduction

The American Heart Association's (AHAs) Strategic Policy Agenda provides direction on policy issues and positions to federal, state and local advocacy staff. Using the Association's 2020 impact goals, priorities and mission – to build healthier lives, free of heart disease (CVD) and stroke – as its driving forces, the Strategic Policy Agenda is a product of a rigorous internal process using evidence-based research and thorough review. Leading clinicians, scientists, and Association volunteers and staff help create the Strategic Policy Agenda to highlight the impact of advocacy work on the Association's mission, as well as its policy priorities. Essential to this concerted effort includes the Association's commitment toward greater health equity and how it plays a pivotal role in the cardiovascular health of all Americans.

Evidence-based policy making

The use of basic, clinical and population research to expand and strengthen the evidence base for the American Heart Association's policy development, advocacy work, and implementation evaluation. Additionally, the Association recommends viewing all policy decisions through an evaluation lens, which measures the impact of targeted improvements, the cost-effectiveness of policy interventions, and the extent to which vulnerable populations are reached and health disparities are addressed.[1] As we focus our work to achieve the AHA's 2020 Impact Goals and begin to think about the next decade, we are reviewing our strategic policy agenda for its health impact, strategic alignment, evidence-base, positioning, feasibility and other important considerations that we have in our policy checklist. Scoring our policy agenda based on these criteria is important for future strategic planning, engaging with the funding community, and internal prioritization and resource management. This is an evolving process with ongoing feedback to guide and improve upon our work. We will continue to provide the rationale for advocacy's contribution to improve the cardiovascular health of the US population and reduce heart disease and stroke mortality through policy, environment, and systems change.

Addressing Health Equity through Policy: Intersecting with the Social Determinants of Health

As an organization dedicated to improving the cardiovascular health of ALL Americans and decreasing death and disability from heart disease and stroke, the American Heart Association understands that addressing health equity in all of its work is paramount. We cannot ignore the disproportionate burden of disease in different racial/ethnic populations, in low socioeconomic populations, in those with less education, in different geographies, by sexual orientation or sex, or in those who are experiencing mental illness or suffering from addiction. The burden of cardiovascular disease is growing faster than our ability to ease it, putting an increasing strain on the US health care system, health care costs, our productivity, and well-being.[2] Distressingly, for the first time in recent decades, the rate of decrease in death rates for heart disease and stroke has flattened and even worsened for our most vulnerable populations.[3] Life expectancy for men in the US with the lowest income is 14.6 years lower than men with the highest income and for women the difference is 10.1 years.[4]

We have to tailor our policy development and advocacy efforts to address the unique challenges in specific communities and segments of the population if we are going to really address America's health challenges. Effective community prevention policies address the root causes of chronic disease in places where people live, work, learn, and play. The American Heart Association employs a targeted universalism approach to its advocacy work which addresses the inherent flaw in universal policy where there is an assumed universal norm that can in fact exacerbate disparity.[5] In other words, universal policy often treats people the same even though they live in different circumstances and the resulting policy implementation can lead to greater inequity. Targeted universalism is an alternative to universal policy where a problem is identified that particularly impacts a vulnerable segment of the population, and then a solution is proposed that can be broadened to cover as many people as possible.[5] Statistics show an alarming rate of obesity, high blood pressure and stroke risk among African Americans, higher levels of diabetes among Hispanic and Native American populations, and in economically disadvantaged neighborhoods there is often limited access to recreational facilities, parks and paths for safe walking, and fewer grocery stores for buying fresh fruits and vegetables. Research by the Centers for Disease Control and Prevention shows that where you live is as equally important to your health as how you live.[6] Recognizing these disparities, we can conduct targeted policy development that addresses disparities and then is broadened to optimize cardiovascular health across the population.

The social determinants of health (SDH) are the conditions in the social, physical, and economic environment where people are born, live, work, and age.[7] SDH consist of policies, programs, institutions and other aspects of the social structure, including the government and private sectors, as well as community factors that are shaped by the amount of money, power and resources that people have.[8] Recognizing the increasing evidence demonstrating these factors as part of the root cause of disease, the American Heart Association (AHA) is expanding

its focus on health equity in policy development, strategic planning, and evaluation of health impact and highlighting where our work intersects with the SDH. We also want to identify and collaborate with key partners who are working on SDH, and bring health equity to policy development, policy implementation, and the long-term sustainability of interventions.

Highlights of Advocacy Successes in Health Equity

By leveraging its existing collaborative efforts and wanting to explore new, innovative partnerships for ongoing discussions around health equity, the AHA is poised to make an even greater impact on CVD. The AHA currently collaborates with scientists, clinicians and policymakers to improve the cardiovascular health of all Americans, while also working with volunteers and multi-sectoral stakeholders. The ultimate goal is to make healthy behavioral choices easier, less expensive, more accessible, and more socially normative with the most appropriate policy, systems and environment changes.[9]

Tobacco Control and Prevention

Tobacco control efforts by the AHA and its public health partners, including comprehensive smoke free air laws, tobacco excise taxes, comprehensive cessation benefits in health care plans, and comprehensive tobacco control funding, represent some of the greatest advocacy successes in recent decades, contributing to a relative decline in US cigarette consumption by more than 24 percent over the past ten years.[10] More specifically, these efforts have led to a 63 percent decline in smoking rates in blacks, a 41.5 percent decrease in Hispanics, and a 43 percent decrease in Asians. Although improved, smoking rates in Native Americans are the highest of any racial or ethnic group where 20.3 percent of Native Americans still smoke. Continued efforts to address health disparities are needed in tobacco control and prevention to address geographic, racial and ethnic, mental health, LGBTQ, and SES disparities in the use of tobacco products.

Access to Care

The AHA has worked with The George Washington University [11] to determine the effects of Medicaid expansion and the Affordable Care Act (ACA) on health insurance coverage where it found that more than seven million Americans with or at risk for CVD gained health insurance under the ACA. In fact, the number of uninsured adults ages 18-64 with a CVD risk factor fell by more than 20 percent or 6.2 million, from 31 million in 2013 to 24.8 million in 2014 or from 21.4 percent of those with a risk factor to 17.0 percent. There were improvements across racial and ethnic groups, but the largest changes occurred among African-Americans. For example, the share of African Americans being treated for diabetes who are uninsured fell by more than half between 2013 and 2014. Reductions were somewhat smaller for Hispanic adults, which may reflect insurance barriers that continue to exist for many Hispanic immigrants. The AHA has served as a voice for the millions of CVD patients who often have low SES and otherwise might not have been able to receive treatment for CVD and stroke.

Medicaid Expansion

Medicaid is the nation's largest insurance program and serves a disproportionate share of low-income Americans, who have both higher CVD risk and limited access to care. As of September 2016, 31 states and Washington, DC have expanded their Medicaid programs. While this is a significant accomplishment, the majority of adults with cardiovascular risk who are uninsured live in states that failed to expand Medicaid: 14.6 million out of 24.8 million (59 percent). The non-expansion states have both more adults at risk of CVD and more who remain uninsured than the states that expanded Medicaid. Millions more adults at risk of CVD could gain health coverage if these additional states expand Medicaid and this is a key priority in AHA state advocacy.[12]

Pulse Oximetry Screening – Detecting Congenital Heart Disease

Late detection, diagnosis of, and mortality from congenital heart defects is linked to individual characteristics such as race and ethnicity, maternal age, education level, insurance status and income.[13,14,15] Pulse oximetry has shown to be an effective means for reducing diagnostic gaps and mortality risk for congenital heart defects at a wide array of provider settings, though failure rates are higher in higher altitudes and out-of-hospital-settings.[16,17,18,19,20,21,22] It has been endorsed by most physicians and 43 of 50 states have enacted mandatory screening laws.[23]

Nutrition Standards for Schools Foods and Beverages

The federal nutrition standards for meals and competitive foods in the National School Lunch Program reach approximately 30.5 million children each day in more than 98,413 schools and residential child care institutions and 21.5 million of these children receive free or reduced priced meals.[24] These same standards reach 12.9 million children in the School Breakfast Program where 10.1 million students receive free or reduced priced meals.[25] A recent study predicted the new standards will prevent an estimated 1.8 million cases of obesity and save more than they cost to implement.[26]

Health Equity Summary

The most significant opportunities for reducing death and disability from cardiovascular disease (CVD) in the United States lie with addressing the social determinants of cardiovascular outcomes.[8] The AHA and its policy agenda must continue to address the burden of CVD and stroke, while at the same time considering how our surroundings and environment can have consequences on cardiovascular health. The AHA already depends on partners in the medical, nonprofit and public health environment to inform its policy development, but participating in conversations around health equity to further integrate this principle purposefully into our work is paramount. Working with key stakeholders and institutions of higher learning, AHA is able to identify and address knowledge gaps in current AHA policy positions through evidence-based research. Using this type of research as a foundation, the AHA can achieve its Impact Goals by

developing and supporting policies that go beyond treatment of CVD by addressing public health challenges associated with the determinants of health and health equity.

> *"Health and illness are not distributed randomly, and neither are resources to prevent sickness and disease. Instead, they cluster at the intersections of social, economic, environmental, and interpersonal forces."*[1]

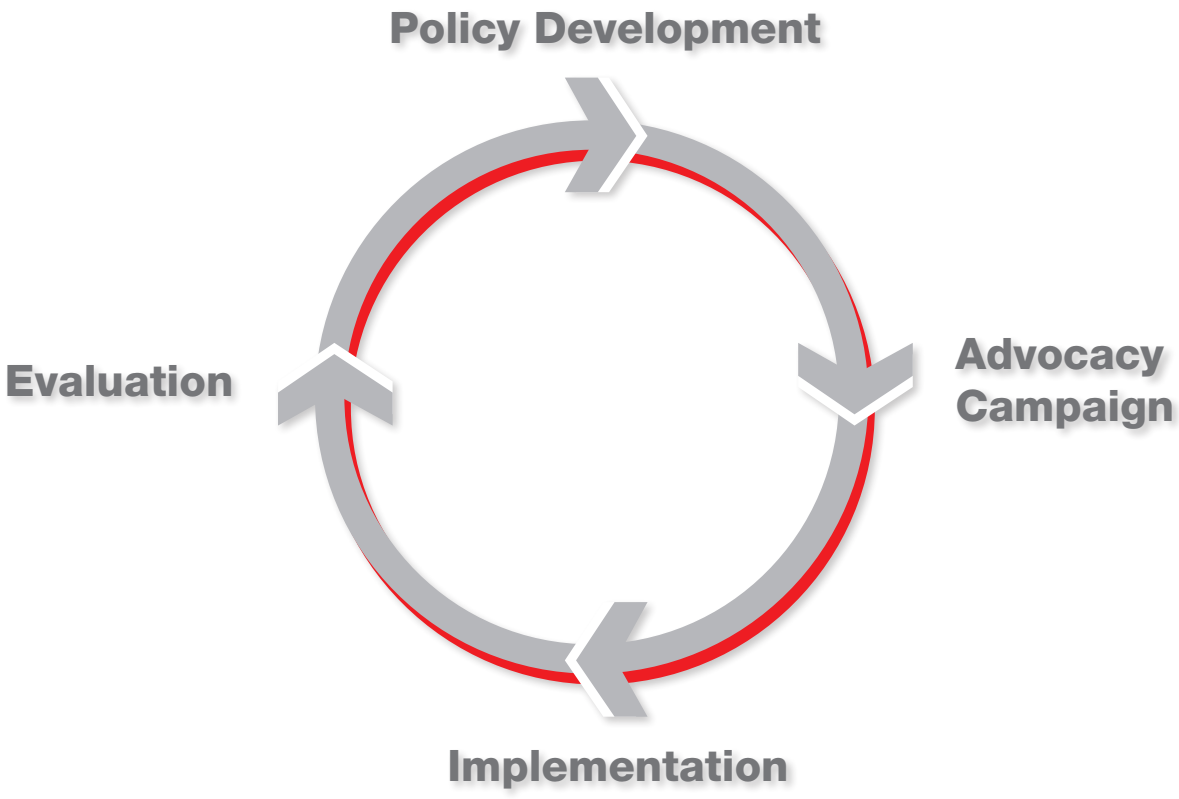
Measuring Our Impact

As an evidence-based policy making organization, the American Heart Association views its policy decisions through an evaluation lens. This allows the association to measure the impact of targeted improvements, the cost-effectiveness of policy interventions, and the extent to which vulnerable populations are reached and health disparities are addressed. This evaluation allows the advocacy department to provide the evidence for advocacy's contribution to improve the cardiovascular health of the US population and reduce heart disease and stroke mortality through policy, environment, and systems change.

To assure our policy work is contributing to the AHA's Impact Goals and provide important feedback to the field, external partners, and key stakeholders, it is important for the AHA to measure the impact of policy implementation. It is not enough to enact legislation or implement regulation. We have to understand whether implementation was successful, whether there were barriers or unintended consequences and whether there was a health impact. Through the final years of this decade, the policy research department will:

- Coordinate with the Center for Health Metrics and Evaluation to link with available and diverse surveillance systems to assess policy impact on population reach, health equity, and other metrics related to our mission and impact goals.
- Conduct original research pre/post implementation to determine the consequences of our work.
- Model the potential impact of our work on new, emerging, and current priorities.

Evaluating for Impact



STRATEGIC PRIORITIES: 2017-2020

Continuing Leadership in Heart Disease and Stroke Research – Focusing on this priority helped reduce CVD deaths by 40 percent from 2000 to 2009 and 37 percent for stroke during same timeframe. It includes all forms of scientific studies like basic and clinical science, health services, genomics and comparative effectiveness research. AHA research focuses on four areas and includes 1) restoring and protecting funding from the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Patient-Centered Outcomes Research Institute (PCORI), Centers for Medicare and Medicaid Services (CMS) Innovation Fund and Agency of Healthcare Research and Quality (AHRQ) 2) collaborating with state health departments and regulatory agencies 3) removing barriers to medical research and 4) increasing participation of women, racial and ethnic minorities, and the elderly in clinical research.

Advocating for Greater Prevention and Healthy Lifestyle – This priority area covers all of the association's work on nutrition/diet, physical activity, tobacco, obesity, and air pollution where the emphasis is on large-scale population health impact with upstream policy, systems, and environment changes.

- **Nutrition:** Addressing access to healthy, affordable foods and beverages, transforming the food system, and providing fully transparent nutrition labeling so consumers can make informed food and beverage choices are critical emphases in our policy agenda to promote healthy eating across the population.

  The AHA/ASA supports policies that:

  - Promote robust nutrition standards for foods and beverages in schools, early care and education, and out-of-school programs
  - Improve food service guidelines for foods and beverages served and sold in government buildings, hospital systems, major employers, and public venues
  - Reduce sodium, trans fat, and added sugars in the food supply
  - Improve and increase transparency of food labeling
  - Implement restaurant menu labeling
  - Increase access to affordable, healthy foods in the community through Farmers' Markets, the Fresh Fruit and Vegetable Program, Farm-to-School Program, Community/School Gardens, Mobile Food Trucks, and Food Banks
  - Increase healthy food and beverage purchasing in government feeding programs
  - Support multi-pronged policy approaches to reducing sugar-sweetened beverage consumption including sugary drink taxes, warning labels, removing them as defaults for kids meals in restaurants, addressing placement and promotion in retail outlets and food service, and removing them from schools, out-of-school time programs, and early care and education
  - Increase access to free potable water in schools and communities
  - Reduce unhealthy food marketing to children

- **Physical Activity/Physical Fitness:** Our work in this area addresses American's sedentary lifestyle in schools, communities, and workplaces and calls for more physical activity through increased frequency of physical education, changes to the built environment and recreational spaces, and the use of science-based physical activity guidelines.

  The AHA/ASA supports policies that:

  - Regularly update and revise the Physical Activity Guidelines for Americans
  - Support appropriations for and delivery of enhanced physical education in schools
  - Promote active transportation in communities including Safe Routes to School, Complete Streets Policies, and increased funding for biking, walking, and rolling
  - Increase the availability of parks and recreational facilities in communities, including shared use policies
  - Support robust physical activity standards in early care and education and out-of-school time programs
  - Support worksite health promotion programs, policies and design of workplaces to promote physical activity and overcome sedentary work environments
  - Increase screening for and prescription of physical activity/physical fitness within payment and delivery systems of care

- **Tobacco Control and Prevention:** Tobacco prevention and control efforts by the AHA and its public health partners represent some of the greatest advocacy successes in recent decades, contributing to a relative decline in US cigarette consumption by more than 24 percent over the past ten years. More work remains though as new tobacco products enter the marketplace and significant disparities remain in tobacco use.

  The AHA/ASA supports policies that:

  - Promote comprehensive clean indoor air laws
  - Increase tobacco excise taxes
  - Raise the purchasing age for tobacco to 21 (Tobacco 21)
  - Develop and enforce comprehensive smoke-free policies in multi-unit housing
  - Provide more funding to tobacco prevention and cessation programs
  - Eliminate the sale of tobacco products in pharmacies and other health-related settings
  - Continue supporting FDA's robust regulation of tobacco
  - Provide comprehensive coverage of tobacco cessation services in public and private health care plans

- Address the increasing use of new tobacco products such as e-cigarettes and reduce youth access to these products

Air Pollution: The American Heart Association's 2010 scientific statement on particulate matter that fine particulate air pollution can trigger cardiovascular disease mortality and nonfatal events, and reduces life expectancy. The association has weighed in at the federal level to support robust clean air standards.

The AHA/ASA supports policies that:

- Promote robust Environmental Protection Agency regulations that strengthen clean air standards

Access to Appropriate and Affordable Healthcare – Driven by the Association's belief that all residents of the US should have access to high quality healthcare, this strategic priority works to expand and protect access to affordable, adequate, transparent insurance coverage for all Americans. This priority also addresses the workforce and system capacity demands of a rapidly aging and increasingly diverse population, as well as the unique needs of urban and rural populations.

The AHA/ASA supports policies that:

- Protect Medicare, Medicaid and CHIP, particularly for the most vulnerable individuals by ensuring that changes to the program emphasize improvements in health care value, promote prevention and coordinated, high quality care
- Advocate for Medicaid expansion in states that have not yet done so and strong patient protections along with any Medicaid reforms
- Ensure that replacements to the Affordable Care Act maintain or exceed its coverage, quality, and access gains
- Address administrative barriers to, and support payment models for, the use of telehealth and mobile health technologies
- Support adequate supply of, and access to, affordable pharmaceuticals and devices
- Ensure appropriate capacity and diversity of skill, expertise, and experience across the healthcare workforce
- Provide training and financial support for family caregivers

High Quality, High Value Healthcare – The triple aim, defined as better health, better healthcare and care at lower costs, serves as the foundation for this AHA policy priority that addresses adherence to clinical guidelines and care protocols, promotes safe, evidence-based diagnosis and treatment of CVD and stroke, and supports patient quality of life throughout the disease trajectory. Health information technology and emerging electronic health platforms provide the infrastructure necessary to support care delivery and new models and payment systems seek to ensure patients receive the right care at the right place, at the right time.

The AHA/ASA supports policies that:

- Facilitate the development of comprehensive, coordinated systems of care for stroke, STEMI, and OHCA that include the use of accredited Primary Stroke Center, Comprehensive Stroke Center and Acute Stroke Capable Facility designations
- Adopt a strong chain-of-survival, including access and use of automated external defibrillators (AEDs), first aid credentialing, quality school based CPR/AED programs, EMS triage and transport protocols and support for NEMSIS
- Promote pulse oximetry screening for newborns
- Encourage payment and delivery system reforms that improve the safety, effectiveness, efficiency, equity, timeliness, and patient-centeredness of care
- Address barriers to medication adherence
- Support innovation in genetic testing while enacting the appropriate regulatory oversight to protect patients and assure the validity of test results
- Ensure access to high quality palliative care services from the onset of disease
- Support an FDA approval process that promotes safe, evidence-based, treatments for CVD and stroke patients
- Encourage the use of registries to support patient care and enable providers to implement quality improvement and population health programs
- Promote the use of risk-adjusted, standardized, evidence-based quality and performance measures, including those that assess patient satisfaction, access and convenience

Rehabilitation – Effective rehabilitation for cardiovascular disease and stroke patients is essential for returning to quality of life, preventing recurrence, slowing disease progression, and recovering from debilitating injury. Despite clear benefits, cardiac rehabilitation, especially, is significantly underutilized and there are barriers for accessing both stroke and cardiac rehabilitation. These may include inadequate referral, limited health insurance coverage, conflicts with home or work responsibilities, and lack of program availability and access. New delivery models for health care offer opportunities to address patient barriers and lower costs. At the same time, health practitioners must fully understand and appreciate the benefits of rehabilitation for their patients.

Cardiac Rehabilitation: The wide treatment gap between the benefits obtained from cardiac rehabilitation and participation in these programs has to be addressed.

The AHA/ASA supports policies that:

- Minimize co-pays for cardiac rehabilitation
- Change the supervision requirements
- Incentivize physician referral to cardiac rehabilitation within quality measures
- Explore alternative delivery models for cardiac rehabilitation in community and home settings
- Provide access and coverage to exercise rehabilitation for patients with peripheral artery disease

- **Stroke Rehabilitation:** Guideline recommended rehabilitation for stroke should be encouraged through payment and systems of care

  The AHA/ASA supports policies that:

  - Assure adequate coverage/reimbursement for comprehensive stroke rehabilitation
  - Broadly implement automatic and coordinated referral strategies

Improving Surveillance for Heart Disease, Stroke, and Related Health Factors – To assess the success of policy interventions and programming on improved cardiovascular health and heart disease and stroke mortality, surveillance, monitoring and evaluation are critical. This priority addresses the need for more robust measures in programs like the National Health and Nutrition Examination Survey (NHANES). Clinical registries collect information on healthcare trends, assess how healthcare elements function, create a better understanding of the prevalence and impact of disease. These registries also help monitor healthcare needs and services used by underrepresented or low-resource populations.

The AHA/ASA supports policies that:

- Create federal, state and local CVD and stroke registries in order to monitor incidence and support the development of relevant quality improvement initiatives
- Encourage the use of patient-centered, evidence-based, broadly-adopted registries to meet many of the quality improvement and reporting requirements of federal programs and those enacted in health reform
- Encourage the use of registries as an efficient data collection tool as part of payment and delivery reform initiatives
- Enhance national surveillance databases to improve data capture on cardiovascular health metrics and progress on environment, systems, and policy change
- Facilitate data platform sharing across private/public sectors to optimize precision medicine initiatives

Protecting Nonprofit Sector Interests – Nonprofits can yield significant dividends for governments and society by confronting public health challenges in communities across the US. This priority highlights the important role nonprofits play in improved health outcomes for vulnerable populations as the AHA works collaboratively with other nonprofits to monitor and ensure that legislative and regulatory policies support the continued vitality of the sector. These policies include promoting a tax policy conducive to charitable organizations, supporting the charitable tax deduction, encouraging volunteerism, preserving the current Combined Federal Campaign, maintaining nonprofit postal rates, and safeguarding the ability of nonprofits to engage in advocacy work.

Cross-Cutting Issues For other areas of strategic importance to the Association, the policy approaches used to address them cut across the domains, with elements that draw from two or more of the priorities.

- **High Blood Pressure:** With 85.7 million adults estimated to have hypertension, improving the diagnosis, treatment, and control of the condition is critical for achieving our impact goals and improving the cardiovascular health of all Americans.

  The AHA/ASA supports policies that:

  - Drive adoption and use of AHA hypertension algorithm at the point of care
  - Pursue payment and outline value for evidence-based remote monitoring devices to support hypertension control
  - Support methods that improve medication adherence, particularly among individuals taking drugs to treat hypertension
  - Support implementation of drug formulary policies consistent with the AHA's Statement on Drug Formularies
  - Promote Public Funding for Hypertension Control Programs
  - Support FDA Voluntary Sodium Standards
  - Protect nutrition standards for foods in schools and other government programs
  - Promote nutrition standards for foods and beverages purchased and sold by local, state, and federal governments, hospital systems, major employers, etc.
  - Promote nutrition and physical activity standards in early care and education
  - Improve food labeling
  - Support reimbursement for, and optimal delivery of, intensive diet and exercise counseling for those diagnosed with hypertension
- **Cholesterol:** It is estimated that 28.5% of the US adults has high low-density lipoprotein cholesterol. This new strategic focus of the Association will help improve adherence to treatment guidelines and access to therapies in order to increase cholesterol control.

  The AHA/ASA supports policies that:

  - Support methods that improve medication adherence, particularly among individuals taking drugs to treat elevated cholesterol
  - Support implementation of drug formulary policies consistent with the AHA's Statement on Drug Formularies
  - Balance the innovation pipeline and therapeutics regulatory approval process such that resources may be allocated to support medical innovation while ensuring appropriate access to, and availability of, treatments
  - Ensure the consideration of the patient perspective when developing definitions of "value"
- **Telehealth:** Telehealth is becoming increasingly common in multiple care settings in the areas of cardiovascular disease and stroke. With healthcare costs, physician shortages, and the demand for healthcare skyrocketing, telehealth has proven to be an effective means for delivering quality, cost-

effective care for those who ordinarily lack access to it. But with existing reimbursement barriers, concerns regarding patient data privacy and accuracy, and the lack of interstate provider licensure, the benefits of telehealth have yet to be fully realized.

The AHA/ASA supports policies that:

- Remove existing Medicare reimbursement barriers for telehealth, and thus ensure that all beneficiaries have access to quality CVD and stroke treatment regardless of their geographical location
- Ensure that a coverage mandate exists in all states, so that third party payers must offer specific, evidence-based telehealth interventions as covered services to the same degree as traditional, in-person healthcare encounters
- Ensure that properly credentialed providers are able to provide quality care across state lines via a multi-state licensure system that follows that strictest standards of medical ethics and guidelines
- Encourage use of telehealth to reduce health delivery problems, such as provider shortages
- Ensure that adoption of telehealth does not sacrifice quality or patient privacy and safety, such as by restricting patient access to limited networks of telehealth specialists rather than in-person specialty care, and promotes high quality care delivery as outlined by the IOM
- Encourage the development of simpler, less expensive technology platforms that allow for inter-operability between systems and keep the patient burden and costs for healthcare systems as low as possible
- Ensure that large electronic health record systems incorporate telehealth and make it compatible with traditional health records to promote a single integrated health record for all patients
- Encourage the development of improved education for providers to simplify the process of delivering telehealth and increase adoption among providers

The Policy Research Department links scientists, clinicians and policymakers to improve cardiovascular health and decrease heart disease and stroke mortality. For more information, visit ***http://bit.ly/HEARTorg-policyresearch*** *or connect with us on Twitter at* ***@AmHeartAdvocacy*** *using the hashtag* ***#AHAPolicy****.*

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