



WINTER 2016 POLICY REPORT

Linking scientists, clinicians and policymakers to help improve cardiovascular health and decrease heart disease and stroke mortality.

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“In order to continue progress towards the Association’s 2020 impact goal, a strong foundation in robust, evidence-based policy is critical.”

LETTER FROM THE CHAIR

As Chair of the American Heart Association’s Advocacy Coordinating Committee, it is my pleasure to share the fifth issue of our Policy Report. We were very pleased with the welcome reception from readers to our updated look and layout that debuted in our last issue and are excited to continue with its more user-friendly design. Additionally, the recent transformational election has reaffirmed our need for evidence-based, timely policy analysis and strategic thinking in the coming weeks and months in order to guide our work as we respond to the adjusting landscape.

This edition includes the most recent policy publications of the department, including new policy statements on palliative care and telehealth, two emerging priority areas for the Association. As a cardiologist, I regularly see patients suffering from the symptoms of their condition and the treatments they are undergoing to treat it. Palliative care has a unique role to play for patients with cardiovascular disease and stroke, and this policy statement will help guide the Association’s efforts to make it more available and accessible to patients. Additionally, telehealth has the ability to expand the availability and accessibility of a wide range of high-quality services, and the new statement outlines the Association’s position to support it. This issue also includes a policy statement on Cardiac Emergency Response Plans for schools to ensure that nationwide our students, as well as their educators and families, are prepared to respond to a cardiac emergency. We are also excited to release the results of work done by colleagues at The Milliken Institute School of Public Health that assesses the health insurance coverage of American adults who are at risk of, or who have experienced, cardiovascular disease, and compare those who live in states that expanded Medicaid under the Affordable Care Act to those who live in states that did not. Lastly, this issue includes a summary of an analysis conducted by the Urban Institute and commissioned by the Association to assess the best approach to structuring a sugary beverage tax, as well as the Association’s recently updated position on sugary beverage taxes. It recommends the use of a tiered approach based on grams of sugar, levied by volume and supports dedication of a portion of the generated revenue to primary and secondary prevention programs, counter-marketing programs, or other investments that address population health.

As always, we welcome your response and feedback on this Policy Report, as well as all of the work that we do to improve the lives of all Americans. Please continue to contact us at policyresearch@heart.org.

Sincerely,

John Warner, MD
Chair, Advocacy Coordinating Committee

HOW TO USE THIS REPORT

- Use data from the policy report in your organization’s internal communications to support statements regarding cardiovascular disease (CVD).
- Send a copy to your professional contacts in the public, private and nonprofit sectors who support the Association’s mission or have a stake in cardiovascular health.
- Share with your connections in local media markets by referencing how Association policy translates into improved health outcomes and can be tied to broader health policy issues.
- Use social media icons to quickly share policy updates and statistics with your network.



PALLIATIVE CARE AND CARDIOVASCULAR DISEASE AND STROKE: AN AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION POLICY STATEMENT



Palliative care is patient and family-centered care that optimizes health-related quality of life by anticipating, preventing and treating suffering in people with advanced illnesses like cardiovascular disease (CVD) and stroke. Through communication, shared decision-making, advance care planning, and attention to distress (physical, emotional, spiritual or psychological), palliative care can help address treatment options and long term prognoses.

This is particularly important for the patients with advanced CVD and stroke who face the long-term challenges and burden of their conditions. Patients with advanced heart failure and stroke survivors sometimes experience poor health-related quality of life as a result of deteriorating health, symptom distress, and complex care regimens. Family members, who often act as primary caregivers, can experience psychological stress as they deal with physical, emotional, and cognitive changes in their loved one.

“The mission of the AHA/ASA includes increasing access to high-quality, evidence-based care that improves patient outcomes, such as health-related quality of life, and is consistent with patients’ values, preferences and goals. Awareness of, and access to, palliative care interventions aligns with the AHA/ASA mission and goals.”

Several barriers exist, however, to the receipt of palliative care by patients and include: reluctance of providers to refer patients to palliative care due to lack of knowledge about benefits or availability of services; provider discomfort in communicating with patients and families about palliative care; and limitations in payment systems for comprehensive palliative care services.

This policy statement highlights the importance of palliative care for patients with CVD or stroke, discusses these barriers to patients’ receipt of it, and provides recommendations for policy makers to further the access to, and receipt of, high-quality palliative care. The Association’s policy recommendations span five categories that include: federal agencies, state agencies, payer-provider relationships, health systems/care transitions, and palliative care education and specialty certification.



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3 THINGS TO KNOW

1

This policy statement provides background on the importance of palliative care as it pertains to patients with advanced cardiovascular disease and stroke, their families and their unique needs.

2

Integrating palliative care in the management of patients with advanced CVD and stroke may provide the benefits of: Improved patient and caregiver understanding of disease, treatment, and prognosis; improved treatment of symptoms and relief of suffering; shared decision making based on patient values, preferences, and goals; and improved patient and caregiver outcomes.

3

The policy statement makes 28 policy recommendations across five categories that include federal agencies, state agencies, payer-provider relationships, health systems/care transitions, and palliative care education and specialty certification.



RECOMMENDATIONS FOR THE IMPLEMENTATION OF TELEHEALTH IN CARDIOVASCULAR AND STROKE CARE: A POLICY STATEMENT FROM THE AMERICAN HEART ASSOCIATION



Heart disease and stroke continue to be a significant public health burden. With healthcare costs projected to reach \$1 trillion by 2030, innovative strategies are needed to increase the value of healthcare by increasing quality of care and lowering costs. Enhancing patient access to care via telehealth is one important strategy to help address this challenge.

“...telehealth may increase access and convenience for cardiovascular disease and stroke patients. This is especially true for vulnerable cardiovascular disease or stroke patients who...may not otherwise access specialty health care services.”

This new policy statement from the American Heart Association aims to provide a comprehensive review of the scientific evidence evaluating the use of telehealth in cardiovascular and stroke care and to provide consensus policy recommendations. It evaluates the effectiveness of telehealth in advancing healthcare quality, identifies legal and regulatory barriers that impede telehealth adoption or delivery, proposes steps to overcome these barriers, and identifies areas for future research to ensure telehealth continues to enhance the quality of cardiovascular and stroke care.



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3 THINGS TO KNOW

- 1 Telehealth can reduce the burden of heart disease and stroke, make care more accessible and affordable, and reduce many widespread disparities in access, particularly those due to geography or provider shortages.
- 2 Barriers to the effective implementation of telehealth across broad populations of patients and providers can be broken out into three large areas: legal/regulatory, health data security and accuracy, and public or private insurance reimbursement.
- 3 When implemented, telehealth should optimize quality of care as defined by the IOM. Consensus recommendations should guide the development of quality management programs specific to disease-based use of telehealth.



CARDIAC EMERGENCY RESPONSE PLANNING FOR SCHOOLS: A POLICY STATEMENT



A Cardiac Emergency Response Plan (CERP) can increase sudden cardiac arrest (SCA) survival rates by 50% or more by enabling a trained lay-responder team to take action. The safety of students, school staff and visitors can be enhanced with a coordinated, practiced response plan where school CERP teams feel

empowered to administer life-saving care until Emergency Medical Services (EMS) arrives. Designed to be stand-alone guidelines or merged with a school's existing medical emergency response plan, the CERP can be used by school personnel, healthcare providers, boards of education and school safety advocates to better prepare for SCA.

This new policy statement provides a national model for school stakeholders to develop, implement, practice and evaluate a CERP, while addressing the legal aspects and critical nature of training and drills in bringing a CERP to fruition. The statement also makes recommendations to support the adoption and practice of CERPs in schools.

- All schools should have a CERP in place that contains the minimum, evidence-based core elements:
 - Establishing a Cardiac Emergency Response Team
 - Activating the team in response to an SCA
 - Implementing AED placement and routine maintenance within the school (similar to fire-extinguisher protocols)
 - Disseminating the plan throughout the school campus
 - Maintaining ongoing staff training in CPR/AED use
 - Practicing use of drills (akin to fire and lock-down drills)
 - Integrating local EMS with the plan
 - Reviewing and evaluating the plan on ongoing and annual basis
- State laws, regulations, and related educational standards should require schools to develop and maintain a CERP integrating the core elements.
- Appropriations should be made available to support the development, implementation, and evaluation of CERPs in schools. CERPs should still be in effect where related appropriations are lacking; in these cases, indirect sources of community or EMS-related support should be used.



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3 THINGS TO KNOW

1

This policy statement is a collaborative effort of organization representatives convened by the American Heart Association.

2

The participating partner organizations were American Academy of Pediatrics, the American College of Cardiology, the National Association of School Nurses, Parent Heart Watch, Project ADAM, SHAPE America, Sudden Cardiac Arrest Foundation, The Kimberly Anne Gillary Foundation, and the University of Georgia.

3

A CERP toolkit can be found at www.heart.org/cerp.



EFFECTS OF MEDICAID EXPANSIONS & THE AFFORDABLE CARE ACT ON HEALTH INSURANCE COVERAGE OF AMERICANS AT RISK OF CVD

Medicaid is the nation's health insurance program for low-income Americans and is a vitally important part of the U.S. health care system. It covers many of the nation's poorest and sickest patients and provides a critical financing mechanism for the health care services these individuals receive – including care related to cardiovascular disease (CVD). Under the Affordable Care Act (ACA), expansion of Medicaid to cover low-income adults up to 138% of the poverty level resulted in 9.6 million individuals gaining coverage from 2013 to 2015, accounting for more than half of coverage gains during that period.¹ To better understand the impact of this Medicaid expansion on patients at-risk or living with CVD, the American Heart Association contracted with researchers at The Milken Institute School of Public Health to assess the health insurance coverage of American adults who are at risk of, or who have experienced CVD, and compare those who live in states that expanded Medicaid eligibility under the ACA and those who live in states that did not expand Medicaid.

“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 states expand Medicaid.”

Among the key findings:

- 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%). The non-expansion states have both more adults at risk of CVD and more who remain uninsured than the states that expanded Medicaid.
- In states that did not expand Medicaid by 2014, the number of adults at risk of CVD who were uninsured declined from 17.3 million in 2013 to 14.6 million in 2014 or from 23.2% of those at risk to 19.4%. In states that expanded Medicaid by 2014, the number of uninsured fell from 13.8 million in 2013 to 10.2 million in 2014, from 19.6% of those at risk to 14.5%.
- Some subpopulations are at higher risk of being uninsured:
 - Hispanics were consistently more uninsured than those who are not Hispanic, while non-Hispanic whites were least likely to be uninsured.
 - Women were often more likely to be uninsured than men.
 - Those who are younger (18-34 years old) are usually more uninsured than older adults (35 to 64).
- In states that expanded Medicaid, the number of adults who ever had at least one of these CVD conditions who are uninsured fell from 1.1 million in 2013 to 0.7 million in 2014, or from 13.8% to 9.4%. In contrast, there was almost no change in the number of uninsured in non-expansion states, holding steady around 1.4 million in both years.



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¹ Carman K, Eibner C, Paddock S. Trends In Health Insurance Enrollment, 2013-15. *Health Affairs*. 2015;34(6):1044-1048. doi:10.1377/hlthaff.2015.0266.

² Ku L, Steinmetz E, Bruen B. Effects of Medicaid Expansions and the Affordable Care Act on Health Insurance Coverage of Americans at Risk of Cardiovascular Disease. Report from George Washington University to the American Heart Association; Forthcoming.

3 THINGS TO KNOW²

1

The most common CVD risk factors in the Medicaid population being examined are being overweight or obese or being a current smoker. In 2014, 12.1 million people in non-expansion states were overweight or obese and uninsured, as were 8.5 million living in expansion states.

2

About 2.3 million adults had hypertension and were uninsured in non-expansion states in 2014, as were 1.4 million in states that expanded Medicaid.

3

Some 1.4 million adults had high cholesterol levels and were uninsured in non-expanding states and 1.0 million were in expansion states.

REDUCING SUGAR-SWEETENED BEVERAGE CONSUMPTION: A FOCUS ON SUGAR-SWEETENED BEVERAGE TAXES



The American Heart Association has made it a strategic priority to reduce consumption of sugar-sweetened beverages in the US population to improve cardiovascular health. Over the last several years, the Association's advocacy work addressing sugary drink taxes has significantly evolved and gained momentum. This revised policy statement addresses the current political landscape, the impact of

implementation, how these taxes should be structured, the importance of evaluation, and how the revenue should be reinvested in evidence-based initiatives that improve population health.

“Evidence is increasing that sugar-sweetened beverage taxes are an effective means of reducing sugary drink consumption across the population, but especially in low-income consumers where there are historically a disproportionate burden of chronic disease.”

The American Heart Association supports taxing sugar-sweetened beverages as an important policy intervention within a multi-pronged policy, programmatic, systems, and environment change approach to decrease consumption across the US population with the goal of improving health. Ideally these taxes would be structured in a tiered approach that considers grams of added sugars/fl. oz. (added sugars by 2018 when federal labeling is implemented) and levies the tax by volume, to optimally decrease consumer consumption of less healthy beverages and spur industry reformulation. The Association would not oppose campaigns that take a uniform volume approach of at least a penny per oz. since this has shown efficacy in modeling studies and with implementation in Mexico and Berkeley, especially in vulnerable populations. The American Heart Association will advocate that at least a portion of the revenue is dedicated to primary and secondary prevention programs, counter-marketing programs, or other investments that address population health and will also assure there is rigorous evaluation associated with implementation to optimize impact on population health, revenue generation, and industry reformulation and marketing.



Cite #AHAPolicy



3 THINGS TO KNOW

1

Sugar-sweetened beverages include soft drinks, sodas, fruit drinks, sweetened coffees and teas, energy drinks, sports drinks, and sweetened waters and are the single largest source of added sugars in the American diet, providing over 5% of overall caloric intake. The American Heart Association supports taxing sugary beverages as part of a multi-pronged approach to decrease consumption of these beverages across the US population.

2

Ideally these taxes would be structured to address grams of added sugars/fl. oz. to optimally decrease consumer consumption of less healthy beverages and spur industry reformulation.

3

The American Heart Association will advocate for comprehensive evaluation of tax implementation and will emphasize that at least a portion of the revenue be dedicated to primary and secondary prevention programs, counter-marketing programs, or other investments that improve population health.

REDUCING SUGAR-SWEETENED BEVERAGE CONSUMPTION: A FOCUS ON SUGAR-SWEETENED BEVERAGE TAXES (CONT'D)

The Pros and Cons of Taxing Sugar Sweetened Beverages Based on Sugar Content, The Urban Institute

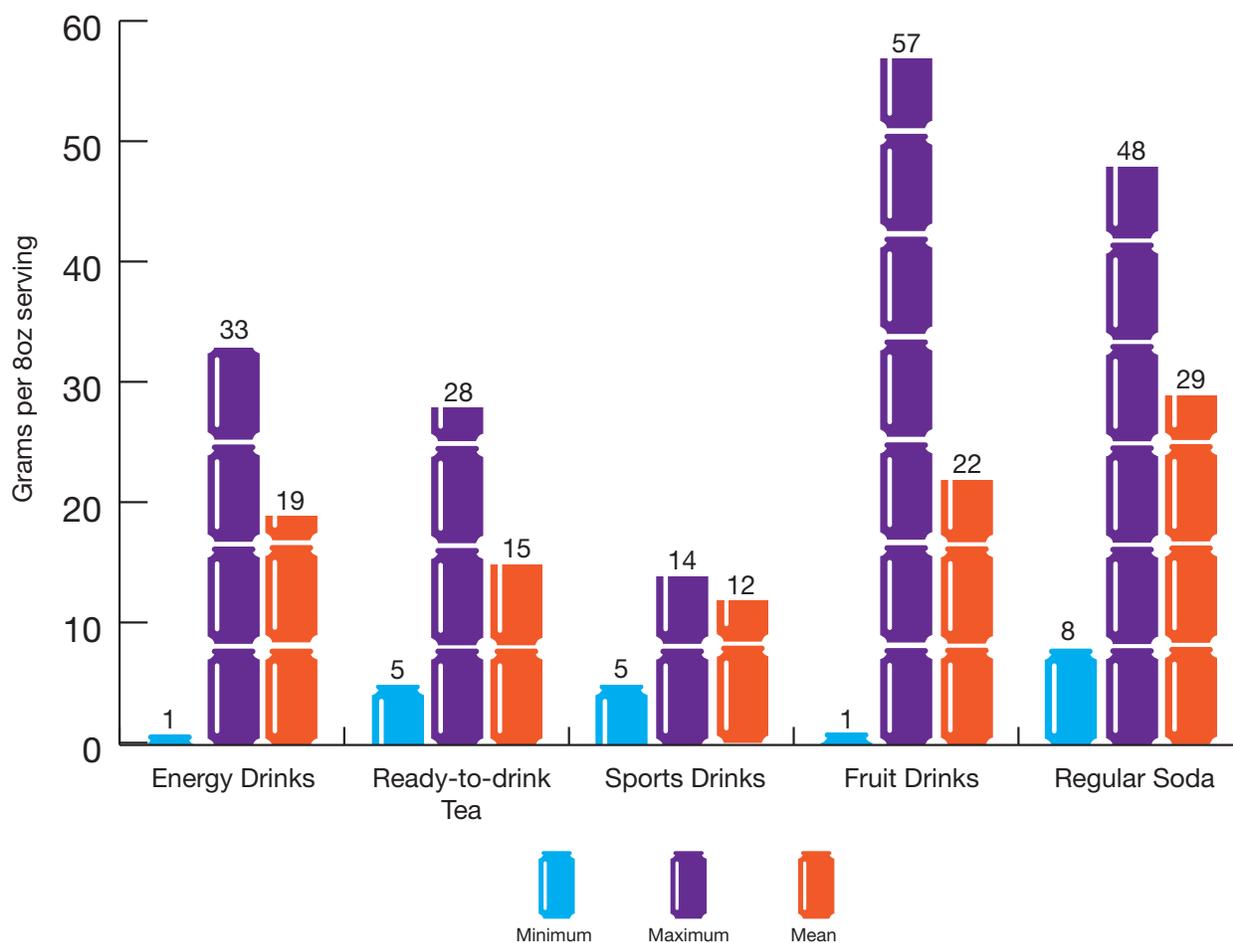
This past year, the American Heart Association commissioned an analysis by the Urban Institute to determine the best approach to structuring a sugary beverage tax. The report will inform AHA's work in tax campaigns around the country. The report found that the amount of added sugar in sweetened drinks varies greatly. If policymakers decide to use taxes on sweetened beverages to discourage consumption of added sugar, they should consider basing those taxes on the amount of sugar drinks contain rather than their volume or retail sales. The report analyzed the potential policy benefits of taxing sugar content; documenting how content-based taxes have been used to discourage consumption of sugar, alcohol, and

tobacco; and examined the legal and practical challenges of implementing such taxes at the federal, state, and local level. The report concludes that taxing based on the amount of added sugar a drink contains, either by taxing sugar content directly or by levying higher volume taxes on drinks with more sugar, is feasible in many jurisdictions and reduces sugar consumption more effectively than comparable taxes on drink volume or sales. Broad-based sales or volume taxes on all soft drinks, however, raise revenue more efficiently. Accordingly, federal, state, and local policymakers face trade-offs between using sweetened-beverage taxes to raise revenue and to discourage consumption of added sugars.



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Sugar Content of Sugar Sweetened Beverages, 2014



Source: Rudd Center for Food Policy and Obesity, 2014, *Sugary Drink FACTS 2014* with calculations.