



SPRING/SUMMER 2017 POLICY REPORT

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

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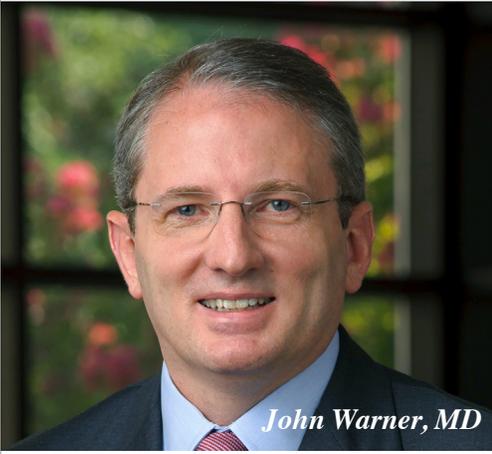
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*John Warner, MD*

“Our need for evidence-based, timely policy analysis has never been as great, as the uncertainty in today’s political environment continues and the potential for significant change for all Americans’ access to high-quality health care services, continues to loom large.”

*Robert Harrington, MD*

LETTER FROM THE CHAIR

As the outgoing Chair of the American Heart Association’s Advocacy Coordinating Committee (AdCC), it is my pleasure to present you with the final Policy Report of my term. This edition includes the most recent policy publications of the department, including *Cardiovascular Disease: A Costly Burden for America, Projections Through 2025*. The report lays out the staggering finding that over the next two decades, the number of Americans with cardiovascular disease will rise to 131.2 million – 45 percent of the total U.S. population – with costs expected to reach \$1.1 trillion. The policy report also includes a Call to Action for involvement by the association and others in payment and delivery system reform efforts. The trend towards value-based payment is not slowing and the paper argues that healthcare practitioners, researchers, and funders should focus efforts on evaluating these new models for their impacts on patients as well as look for opportunities, as appropriate, to drive their adoption. New in this issue is a policy position on the Supplemental Nutrition Assistance Program (SNAP), a component of the upcoming Farm Bill reauthorization. Despite the important role in addressing hunger, SNAP is the only federal feeding program that does not incorporate nutrition standards and data indicate that although diet quality is poor across much of the US population, SNAP recipients have worse diet quality than income-eligible non-participants. The statement outlines the association’s support for nutrition criteria so that government dollars may bring about improvements in the health status of those with the greatest health disparities. The report concludes with a new statement on active transportation – the opportunity to bike, walk, or roll to work, school, or around the community – and outlines the association’s approach to using evidence-based strategies to increase physical activity across the lifespan.

As I become the association’s 2017-2018 President, it is my pleasure to hand over the AdCC reins to Dr. Robert Harrington, an interventional cardiologist and the Arthur L. Bloomfield Professor of Medicine and Chairman of the Department of Medicine at Stanford University. In addition to his clinical and research duties, Bob has been an active AHA Science Volunteer and has served in many roles including as a past chair of Annual Scientific Sessions and as a current member of the AHA Board of Directors. I am excited to see the Committee flourish under his leadership.

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.

CARDIOVASCULAR DISEASE: A COSTLY BURDEN FOR AMERICA, PROJECTIONS THROUGH 2025



Commissioned by the association, this study by RTI International projects the prevalence and costs of CVD from present through 2035. It is an update of projections previously commissioned in 2011, in order to establish a benchmark to assess the impact of current and future CVD policy.

By 2035, CVD prevalence is expected to increase to 45.1%, representing a 30% increase in the number of people with CVD over the next 20 years. Between 2015 and 2035, real total direct medical costs of CVD are projected to more than double from \$318 billion to \$749 billion. Real indirect costs (due to lost productivity) for all CVDs are estimated to increase from \$237 billion in 2015 to \$368 billion in 2035 (55% increase). Total (medical and indirect) costs of CVD are expected to double from \$555 billion in 2015 to \$1.1 trillion in 2035.

“This study is an urgent plea for change and a bleak glimpse of CVD’s wrath in the not-to-distant-future if we don’t reassess our priorities to better emphasize CVD research and prevention.”

Nancy Brown, CEO, American Heart Association

While this analysis acknowledges the enormous progress that has been made in the fight against CVD, it also pinpoints the significant challenges that lie ahead. These findings indicate that CVD prevalence and costs are projected to increase substantially. Effective research, prevention, and treatment strategies are needed to limit the growing burden of CVD.



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3 THINGS TO KNOW

1

Total costs of CVD are expected to eclipse \$1 trillion by 2035.

2

Medical costs will likely triple over the next 20 years for Hispanics, more than double among blacks and be higher for women than men.

3

By 2035, nearly half of the US population is expected to have at least one CVD.



AMERICAN HEART ASSOCIATION'S PAYMENT AND DELIVERY SYSTEM REFORM CALL TO ACTION



The healthcare system is undergoing a transition from paying for volume to paying for value. Clinicians, as well as public and private payers are beginning to implement alternative delivery and payment models, such as the patient centered medical home, accountable care organizations, and bundled payment arrangements. Implementing these new models will necessitate delivery system transformation and will actively involve all fields of medical care, in particular medicine and surgery. This call to action, on behalf of the American Heart Association/American Stroke Association's Expert Panel on Payment and Delivery System Reform, serves to offer support and direction for further involvement by the association. In doing so, it (1) provides baseline review and definition of the present models and some of the early results of these delivery models, including outcomes; (2) initiates a conversation within the association on the impact of payment and delivery system reform, and how the association should engage in the interest of patients; (3) issues a "Call to Action" to the organization and cardiovascular and stroke health professionals across the country to become educated about these models so to as to understand their impact on patient care; and (4) asks the government and other funding agencies, including the association, to begin supporting and prioritizing meaningful research endeavors to further evaluate these models.



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3 THINGS TO KNOW

1

The Centers for Medicare & Medicaid Services has announced achievement of its previously stated goal to tie 30% of Medicare fee for service (FFS) payments to quality or value through alternative payment models by 2016 and is moving toward its 50% goal by 2018. It has also announced that it will connect 85% of all Medicare FFS payments to quality or value by 2018 and 90% by 2019.

2

The Medicare Access and CHIP Reauthorization Act of 2015, created the Quality Payment Program, includes the Merit-based Incentive Payment and Alternative Payment Model programs, hoped to further catalyze the movement of providers and systems into value-based models of care.

3

To be both thoughtful and proactive, the association convened an Expert Panel on Payment and Delivery System Reform in 2015, comprised of clinical and economic experts from leading institutions. It was tasked with assessing the current environment and determining the optimal role for the association in moving forward on behalf of patients.



FARM BILL POLICY AND THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

For more than 50 years, the Supplemental Nutrition Assistance Program (SNAP – formerly Food Stamps) has been vital in addressing food insecurity and nutrition in the United States. The program provides foods and beverages to more than 45 million Americans struggling through underemployment and low or stagnant wages. The majority of benefits go to households with children, elderly adults or those with disabilities. Although diet quality has been steadily improving in the U.S. during the past two decades, overall dietary quality is still poor. Most significantly, there is a widening gap associated with education and income. SNAP is the only federal feeding program that does not incorporate nutrition standards. Despite the important role SNAP plays in addressing hunger, additional data indicate that SNAP recipients have worse diet quality than income-eligible non-participants. There is increasing public support for amending SNAP to add nutrition criteria to encourage the use of government dollars for healthy foods and beverages to improve the health status of those with the greatest health disparities.

In the next Farm Bill, the American Heart Association will advocate for protecting funding for SNAP, SNAP-Ed*, and the Food Insecurity Nutrition Incentives grants while supporting an enhanced pilot program with robust evaluation that incentivizes fruit and vegetable purchases and displaces sugary beverages. The association will also encourage and help inform state waiver applications to the US Department of Agriculture to pilot approaches to increase access to healthy foods and beverages coupled with robust evaluations. Finally, the association will advocate for the Fresh Fruit and Vegetable Program which provides fresh produce to almost a million students in low-income elementary schools across the country.

*SNAP-Ed is the nutrition and physical activity promotion and obesity prevention component of SNAP and has a goal of improving the likelihood that persons eligible for SNAP will make healthy food and lifestyle choices.



Cite #AHAPolicy

3 THINGS TO KNOW

1

Nearly one in seven American households experience food insecurity, lacking the resources for consistent and dependable access to food. SNAP provides an important opportunity to increase access to healthy foods and beverages for those with the greatest need, especially children, the elderly and those with disabilities.

2

Unlike other major federal feeding programs, SNAP does not incorporate nutrition criteria. Diet quality in SNAP recipients, like most of the US population, is poor. For example, in SNAP and SNAP-eligible households, more money is spent on sugar-sweetened beverages (SSBs) than any other food commodity. SNAP benefits paid for 72 percent of the sugary drinks purchased by SNAP households.

3

There is increasing public support for amending SNAP to add nutrition criteria to use government dollars toward healthful items to improve the health status of those with the greatest health disparities.





THE AMERICAN HEART ASSOCIATION POLICY STATEMENT ON ACTIVE TRANSPORTATION

3 THINGS TO KNOW

1

Generally, active transport is associated with more total physical activity, lower rates of obesity and diabetes, and may decrease disparities in meeting the Physical Activity Guidelines for Americans.

2

Unfortunately, research has shown that only 13% of adults spend some time in active transportation on a weekly basis, while 84% of adults used predominantly sedentary transportation. On a typical day, about 1% of residents in the United States report traveling by bicycle. Less than 15% of children bike, walk, or roll to school on any given day and in many school districts across the country the rates are much lower.

3

In the United States, much of our built environment does not support safe and enjoyable active transportation and there are significant disparities in access especially for low-income and vulnerable communities, in rural and urban environments, persons with disabilities, for older individuals and in people of color.



The current prevalence and global reach of physical inactivity has been described as a pandemic with far-reaching health, economic, and social consequences. Promoting active transportation – the opportunity to bike, walk, or roll to work, school, or around the community – through policy, systems and environmental change is one of the leading evidence-based strategies to increase physical activity across the lifespan. Active transportation policy engages the public health, municipal planning, and transportation communities that often speak different languages and have different values and priorities. However, translational resources have been developed. Embedding health within transportation policy can be challenging and requires purposefully convening a wide range of stakeholders to address community planning, street scale-design, health equity, crime, and safety. The development of mixed-use, walkable, bikeable and transit-served communities depends on coordinated land use planning and multimodal transportation investments and collaborative partnerships. For optimal implementation, infrastructure improvements must be accompanied by education, worksite, school and community policies, and a supportive culture that promotes biking, walking, and rolling.

Unfortunately, vulnerable populations including people with low income, racial/ethnic minorities, immigrants, LGBTQ people, older adults, children and people with disabilities often do not live in connected communities, making it harder to access jobs and other economic and social opportunities. Many low-income people who do not own cars also do not have the needed infrastructure to get safely to jobs or essential destinations by walking or rolling through their communities. Prioritizing equity within Complete Streets policies, Safe Routes to School, and biking and walking infrastructure is challenging but essential for providing opportunities for active transit. The American Heart Association supports equitable, evidence-based strategies to improve active transportation for all Americans.



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