



American Heart Association Public Policy Agenda 2010-14

BACKGROUND

The American Heart Association's (AHA's) public policy agenda provides our federal, state and local advocacy staff with strategic guidance and direction on policy issues and positions that align with and support the Association's mission and strategic priorities. Additionally, each year the AHA scans the political landscape to identify opportunities and establishes federal and state priorities that serve to focus our immediate advocacy efforts on those issues that present the greatest opportunity for success in achieving mission and strategic priority related health impact through public policy.

EXECUTIVE SUMMARY

This document provides a comprehensive summary of the policy priorities of the American Heart Association in the areas of heart disease and stroke research, cardiovascular health (nutrition, physical activity, obesity treatment and prevention, tobacco cessation and prevention, and air pollution), high quality/high value of heart disease and stroke care, appropriate and timely access to heart disease and stroke care and protection of the non-profit environment. Included in each of these areas is the Association's commitment to eliminate health inequities and disparities.. Working with our local affiliates and You're the Cure grassroots advocates, the AHA can address legislative and regulatory opportunities that advance our mission through public policy at the federal, state, and local level. Table 1 summarizes the policy and advocacy strategies in each of these priority areas and Table 2 illustrates the impact of AHA's advocacy work on our mission and 2020 goals and metrics to reduce cardiovascular disease and stroke by 20 percent and improve the cardiovascular health of the US population by 20 percent.

The AHA's Advocacy Coordinating Committee (AdCC) - a committee of the Association's national board - is responsible for establishing the Association's policy positions, public policy agenda, and annual legislative and regulatory priorities. The public policy agenda and annual priorities are a product of a rigorous internal process that is informed by our science, guided by our 2020 health impact goal and strategic plan, and refined through the advice and counsel provided by AHA staff and volunteers. These priorities, which are predicated on extensive research and analysis, are realized through legislative and regulatory advocacy and media conducted by staff and AHA's You're the Cure volunteer advocates

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Summary of AHA Policy Priorities for 2010-14

AHA Strategic Priority

Advocacy Plan to Achieve this Priority

Support Heart Disease and Stroke Research

Provide support for basic, population, epidemiological, clinical, translational, health services, outcomes, genomics, and comparative effectiveness research and the overall research environment.

Protect and Increase Funding for:

- The National Institutes of Health (NIH) and the Institutes and Centers within NIH that conduct heart disease and stroke research as well as cross-cutting areas like obesity, and genetics funded in part through the Common Fund;
- The Agency for Healthcare Research and Quality (AHRQ);
- The Food and Drug Administration (FDA);
- The Centers for Disease Control and Prevention (CDC);
- Department of Veterans Affairs;
- State health departments and other state agencies;
- Local health departments

Funding requests for these various agencies goes beyond research to include programmatic, service, and/or evaluation/surveillance funding.

Lift barriers that impede the conduct of medical research:

- Eliminate any unnecessary recruitment barriers created by the Institutional Review Board Process, Health Insurance Portability and Accountability Act (HIPAA) while maintaining the protection of individual health information;
- Protect individuals from genetic discrimination of any kind;
- Protect researcher access to humane animal research.
- Help address barriers to patient participation in clinical research,

Promote Cardiovascular Health

Promote public policies aimed at promoting and improving health factors for all Americans.

Obesity Prevention, Diagnosis, and Treatment:

- Support obesity diagnosis, prevention, and treatment in the healthcare environment;
- Promote adequate surveillance and monitoring of obesity in the population;
- Support comprehensive, evidence-based worksite wellness; address the use of incentives within these programs
- Promote coordinated school health;
- Improve school wellness policies;
- Support obesity prevention in early childhood education;
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Nutrition:

- Improve access to and affordability of healthy foods (farmer's markets, school/community gardens, Fruit and Vegetable Pilot Program, Healthy Food Financing Initiative, incentives for healthy food purchasing within government feeding programs);
- Support menu labeling in restaurants;
- Advocate for more effective food labeling;
- Reduce sodium, trans fat and added sugar in the food supply;
- Discourage food marketing and advertising to children;
- Encourage nutrition education and promotion in schools;
- Strengthen nutrition standards in schools for meals and competitive foods and in all government nutrition assistance or feeding programs;

- Promote robust procurement standards for foods purchased by employers and government agencies
- Advocate for robust surveillance to monitor food composition, food intake, use of the Nutrition Facts Panel, menu labeling, and biologic markers of nutrition important for cardiovascular health.

Physical Activity:

- Support policies that promote quality and more frequent physical education and physical activity in our nation's schools.
- Support efforts to design our workplaces, communities, and schools around active living and integrate physical activity opportunities throughout the day;
- Support policies and programs aimed at improving the built environment and active transport including Safe Routes to School and Complete Streets
- Expand shared use of school and other public and private facilities
- Help implement the National Physical Activity Plan and the Physical Activity Guidelines for Americans.

Tobacco:

- Support increases in tobacco excise taxes and allocate all or a major portion of these revenues to tobacco control and other policies to promote cardiovascular health;
- Establish sustainable funding for tobacco cessation/prevention programs that meet or exceed CDC recommendations;
- Pass and protect comprehensive smoke-free air laws;
- Assure comprehensive implementation of FDA regulation of tobacco;
- Counter unfounded health claims of tobacco "harm reduction" products and strive to eliminate their use particularly in children and young adults;
- Assure comprehensive smoking cessation benefits in Medicare, Medicaid, and other health plans;
- Promote policies that limit the advertising and sale of tobacco products
- Eliminate tobacco sales in pharmacies and other health-related institutions.

Air Pollution:

- Monitor opportunities to influence legislation and regulation at the state and federal level to decrease the amount of particulate matter air pollution from various sources.

***Support High Quality/
High Value Heart Disease
and Stroke Care and
Reduce Health Inequities***

Promote public policies aimed at improving health care quality, reducing health disparities, and promoting high value, evidence-based cardiovascular care.

Improve healthcare quality.

- Promote quality health care through adherence to clinical guidelines and treatment protocols;
- Promote reporting of health care data, including quality measures, new drug and device safety and efficacy data, and other data, by gender, race and ethnicity in order to identify and begin addressing potential health inequities;
- Support the development of disease registries;
- Monitor the role of quality in health care payment systems;
- Continue to monitor, evaluate and promote proposed public policies concerning drug formularies.
- Consider patient preferences within the context of health care resource allocation
- Support delivery system reforms throughout the continuum of care aimed at improved care coordination (including disease management, transitional care, hospice, and end-of-life interventions.) as well as initiatives aimed at

supporting family caregivers of persons with cardiovascular disease and stroke;

- Support comprehensive efforts to reduce health inequities; Monitor the role, development and implementation of electronic medical records, and related health information technology strategies in heart disease and stroke data collection for registries and surveillance;
- Assure that evidence-based lifestyle practices are foremost in cardiovascular health promotion and risk reduction, in accordance with their priority in management guidelines.

Promote safe, evidence-based and high value treatments for cardiovascular disease.

- Promote scientific oversight and patient protections for pharmaceuticals and medical devices;
- Support comparative effectiveness research according to fundamental scientific principles;
- Require appropriate regulatory oversight for marketed genetic and other tests to assure quality.

Ensure Appropriate and Timely Access to Heart Disease and Stroke Care

Advance comprehensive coverage and timely access to appropriate care for heart disease, peripheral artery disease and stroke with a focus on adequate and affordable coverage, appropriate systems of emergency care, telemedicine, and surveillance.

Health Reform:

- Support the successful implementation of the Affordable Care Act.
- Make certain that health coverage provides affordable access to individuals with pre-existing conditions;
- Support health plan coverage that includes coverage for essential health care services including hospital and ambulatory care, prescription drugs, preventive services, emergency care, and rehabilitation;
- Eliminate financial barriers to preventive services in public and private health insurance plans;
- Make certain that health care plan networks include an adequate number and type of providers and provide consumers with complete and understandable information about health plan coverage, costs, and quality;
- Ensure that Medicare and Medicaid continue to be affordable safety nets of coverage for seniors, the disabled and those with low-incomes
- Ensure that the health care workforce includes providers adequate to meet the needs of individuals with or at risk of cardiovascular disease;
- Ensure that personalized healthcare services are accessible to everyone;
- Educate and train the medical workforce to prepare for the expanded integration of genetics into healthcare practice;
- Support efforts to empower patients to participate meaningfully in the management of their CV risk and health;
- Support more public resources devoted to researching the causes and treatment of congenital heart disease along with specialized programs of care for children and adults with CHD and improve the understanding of healthcare utilization, costs and needs for the growing adult population;
- Take a lead role in advocating for public and professional awareness of peripheral artery disease (PAD) and support reimbursement for exercise rehabilitation, diet and weight management therapy for patients diagnosed with PAD.
- Support the establishment of quality community CPR/AED programs
- Support the establishment of quality school based CPR/AED programs.

Systems of Care:

Stroke

- Create inclusive and coordinated statewide systems of care to improve the

treatment of the stroke patient;

- Integrate telemedicine into stroke systems of care;
- Remove barriers for rehabilitation referral and treatment of stroke patients.

STEMI

- Establish STEMI systems of care across the country;
- Promote related training for emergency medical services (EMS) providers related to STEMI care.

Out-of-hospital cardiac arrest

- Implement a community-wide plan to optimize treatment sequentially from successful out-of-hospital resuscitation to hospital discharge;
- A priori agreements between EMS and hospitals should be established with protocol-driven decisions to match patient needs with the capability of the transport-destination hospital to meet those needs.

Telehealth:

- Support and advance the Rural Tech Act, the Medicare Telehealth Enhancement Act and other federal and state legislation that advances telemedicine;
- Advocate that information technology funds appropriated in the American Recovery and Reinvestment Act and other federal legislation be used for telehealth purposes;
- Monitor implementation of the telehealth provision (in the CMS innovation center section) and remote monitoring provisions in health reform legislation.

Rehabilitation:

- Reduce barriers to rehabilitation and recovery services;
- Support more research to define optimal treatment approaches and settings for rehabilitation and recovery;
- Repeal therapy caps;
- Also work at the state level to remove barriers that currently exist limiting the ability of patients to receive appropriate stroke and cardiac rehabilitative services.

Other Emergency Care:

- Promote improving state 9-1-1 systems and emergency medical dispatch (EMD) quality assurance;
- Promote 12-lead electrocardiograms for ambulances that regularly respond to chest pain calls;
- Support strong EMS systems and EMS triage and transport protocols for stroke, STEMI, and out-of-hospital cardiac arrest care;
- Support CPR and AED training for professional and lay rescuers and establish quality community-based AED programs that improve access to and use of automated external defibrillators (AEDs).

Surveillance:

- Establish a National Heart Disease and Stroke surveillance unit to produce annual reports on key indicators of progress in the prevention and management of heart disease and stroke, coordinating efforts with the National Forum;
- Develop surveillance capacity in states, territories and tribal organizations to support program planning, implementation, and evaluation;
- Strengthen and coordinate pre-hospital data collection by increasing NEMSIS data quality and provider participation;
- Promote the establishment and expansion of statewide stroke and heart disease registries;
- Support public funding to advance the clinical decision support programs ACTION Registry-Get with the Guidelines, GWTG-Stroke and other

programs as appropriate and advocate that these programs to serve as the state registry data platforms;

- Establish surveillance capacity for monitoring all metrics for AHA's 2020 Impact Goal, the Million Hearts Initiative and the closely related Healthy People 2020 Objectives.

Protect the Non-Profit Environment

Ensure the continued societal contributions and viability of non-profit organizations by monitoring and as appropriate, including legislative and regulatory efforts that attempt to restrict or prohibit charitable giving and other non-profit efforts and activities.

- Protect non-profit sector interests;
- Promote tax policy conducive to charitable organizations;
- Encourage volunteerism;
- Preserve public funding for voluntary health organizations;
- Safeguard the ability of charitable organizations to engage in advocacy.

THE AHA'S PUBLIC POLICY AGENDA

HEART DISEASE AND STROKE RESEARCH

In working to achieve its mission, the American Heart Association makes medical research a lead priority. The association believes that basic research is the starting point for all medical advances. Learning more about the life processes of the cardiovascular system is the only sure way the AHA can continue to treat—and prevent—heart disease and stroke and promote cardiovascular health for all Americans.

Although the association is the largest supporter of heart and stroke research outside of the federal government and the pharmaceutical industry, the AHA cannot accomplish its mission without the help of research supported by the federal government, primarily the National Institutes of Health (NIH), but also the Department of Veterans Affairs Medical and Prosthetic Research (VA), Agency of Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Centers for Medicare and Medicaid Services (CMS); and the various state agencies. The association also advocates for the identification of additional federal funding sources to supplement, not reduce, monies awarded through the appropriations process. In addition to our work to affect the appropriations process at the federal level the association works to increase state and local level appropriations aligned with our heart disease and stroke prevention policies. State and local appropriations can often act as a match and can increase federal funding. This section focuses on several areas of the association's advocacy/policy agenda on heart and stroke research.

The association's research priority includes all forms of scientific studies, including basic science as well as clinical, translational, health services (outcomes), genomics, and comparative effectiveness research and the overall research environment. Effectively preventing and treating disease depends on accurate knowledge about its causes, on how disease affects the body, on drugs that combat disease, on devices that are safe and that work, and on operations that cure as well as clinical research that helps enable health care professionals to assist their patients and their families in building the skills they need to adopt and maintain a healthy lifestyle. The knowledge, material and skills on which prevention and treatment are based have come from a variety of sources, including information that can only be obtained from research on both animals and humans. Animal research has improved the health and welfare of animals and humans. The decline in death rates in the United States from heart disease and stroke since the 1960s is due to lifestyle changes and new methods of treatment and prevention, many of which are based on animal research. The association generally opposes legislation and regulations that would curtail necessary heart disease and stroke research or make it unduly difficult or costly.

Demographics

Death rates from coronary heart disease have fallen 29 percent from 1998 to 2008 and have dropped for stroke 35 percent during that same time period. (Lloyd-Jones, Adams et al. 2009) This decline is directly related to heart and stroke research, with scientists on the verge of new and exciting discoveries that could lead to innovative treatments and even cures for heart disease and stroke. However, as baby boomers age, heart disease, stroke and other forms of cardiovascular disease will cost more lives and money. Heart disease and stroke are the number 1 and 4 causes of death, respectively, in the U.S. (Lloyd-Jones, Adams et al. 2009) Lifetime cardiovascular disease (CVD) risk in people free of disease at age 40 is 2 in 3 for men and more than 1 in 2 for women. (Lloyd-Jones, Adams et al. 2009) As the baby boomers age, heart disease deaths are projected to increase 2.5 times faster than the population, and the prevalence of heart disease is projected to increase by 16% each decade. (Foot, Lewis et al. 2000) Deaths from the most common type of stroke (ischemic stroke) are projected to increase nearly 100 percent to 275,000 between 2000 and 2032. (Elkins and Johnston 2003) CVD cost our nation an estimated \$298 billion in medical expenses and lost productivity in 2008, making it the most costly disease. (Lloyd-Jones, Adams et al. 2009) A recent study projects that more than 40% of adults in the U.S. will live with cardiovascular disease at a cost to exceed \$1 trillion annually by year 2030 (Heidenreich et al. 2010). This same study forecasts that direct costs for stroke will escalate 238 percent and prevalence will increase 25 percent over the next 20 years (Heidenreich et al. 2010). Treatment costs for CVD are expected to rise 64-84 percent by 2025. (Steinwachs, Collins-Nakai et al. 2000) Stroke treatment alone is projected to exceed \$2 trillion by 2050. (Brown, Boden-Albala et al. 2006)

Research Can Save Money

Heart and stroke research can reduce healthcare costs. For example, every \$1 spent in technological improvements in treating heart attacks saves \$7. (Cutler and McClellan 2001) NIH research has shown that ordinary aspirin, with or without other anti-platelet drugs, can reduce the risk of recurrent stroke. (Sacco, Adams et al. 2006) The drug, tPA (tissue plasminogen activator) is the only FDA-approved emergency treatment for the most common type of stroke. (1995) Patients treated with tPA within 3 hours of onset of stroke symptoms are 30% more likely to have minimal or no disability at a 3-month follow-up. (1995) A recent study estimates the original National Institute of Neurological Disorders and Stroke (NINDS)-funded tPA trial resulted in a 10-year net benefit of \$6.47 billion. (Johnston, Rootenberg et al. 2006) NINDS's Stroke Prevention in Atrial Fibrillation (AF) Trial 1 showed treatment with aspirin or Warfarin could reduce stroke in AF victims by 80%, resulting in a 10-year net benefit of \$1.27 billion, with a savings of 35,000 quality-adjusted life years. (Johnston, Rootenberg et al. 2006) Death rates from CVD have dropped by more than 63% and from stroke by 70% since 1940 in large part as a result of NIH-funded research. (Zerhouni 2006) Reduction in heart disease death rates increased the value of life by about \$1.5 trillion annually from 1970-1990. Eliminating deaths from heart disease would generate about \$48 trillion in economic value from increased life expectancy. (Murphy 1999)

Research Improves Care

Heart and stroke research has revolutionized patient care. The following are some examples of life-saving treatments:

Revolutionary clot-busting drugs reduce disability from heart attack or stroke by dissolving the blood clots that cause the attack.

- The use of drugs to lower cholesterol has reduced the average cholesterol level in the U.S. to the ideal range for the first time in about 50 years; (Schober 2007)
- Small, wire-mesh stents are one option for widening narrowed arteries in the heart or neck;
- Pacemakers, implantable cardiac defibrillators, automated external defibrillators (AEDs), and minimally invasive surgical techniques have significantly improved health care outcomes;
- FDA has approved the first totally implanted permanent artificial heart for patients with advanced heart failure;
- An international research consortium that conducted one of the largest genomic studies ever, identified 29 genetic variations that influence blood pressure, a leading risk factor for heart attack and the major one for stroke. More than half of these genetic variants were previously unknown. This will provide insights into the biology of blood pressure and may lead to novel therapeutic strategies.
- Constraint-induced Movement Therapy—a rehabilitative method forcing use of a partially paralyzed arm—can help stroke survivors regain arm function. Rehabilitation can also include prosthetic valves including those deployed percutaneously, closure devices that can be deployed without surgery.
- Those at highest risk for a second stroke should be treated with aggressive medical therapy alone rather than with a brain stent (NINDS SAMMPRIS 2011)
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The AHA's Policy Agenda to Address Heart Disease and Stroke Research

Increase Funding

The National Institutes of Health

The NIH is our nation's premier medical research agency and includes 27 Institutes and Centers. According to the NIH, it is the primary federal agency for conducting and supporting basic, clinical and translational medical research, and it investigates the causes, treatments, and cures from both common and rare diseases. To reduce disability and death from cardiovascular disease, the Association seeks to obtain steady, long-term significant growth in funding for the NIH, including for heart disease, stroke, sudden cardiac and respiratory arrest, and other cardiovascular diseases. This includes significant real growth in federal funding primarily for medical research programs of the

- National Heart, Lung, and Blood Institute: the NHLBI plans, conducts, and supports research related to the causes, prevention, diagnosis, and treatment of heart, blood vessel, lung, and blood diseases; and sleep disorders. The Institute also administers national health education campaigns on women and heart disease, healthy weight for children, and other topics;
- National Institute of Neurological Disorders and Stroke: the NINDS is the nation's leading funder of research on the brain and nervous system. The Institute's mission is to reduce the burden of neurological disease—a burden borne by every age group, by every segment of society, by people all over the world.

Attention should also be given to other 20 to 22 NIH institutes (out of 27), centers and divisions that conduct heart and stroke research, primarily the:

- National Institute on Aging (NIA): the NIA leads the federal effort supporting and conducting research on aging and the medical, social and behavioral issues of older people;
- National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK): the NIDDK conducts and supports basic and clinical research and research training on some of the most common, severe and disabling conditions affecting Americans. The Institute's research interests include: diabetes and other endocrine and metabolic diseases; digestive diseases, nutrition, and obesity; and kidney, urologic and hematologic diseases; and
- National Institute of Nursing Research (NINR): the NINR supports basic and clinical research that develops the knowledge to build the scientific foundation for clinical practice, prevent disease and disability, manage and eliminate symptoms caused by illness, and enhance end-of-life and palliative care.

NIH-supported research has revolutionized patient care and holds the key to finding new ways to treat and prevent heart disease and stroke and promote cardiovascular health for all Americans, resulting in longer, healthier lives and reduced health care costs. In addition, NIH generates economic growth, creates jobs and preserves the U.S. role as the world leader in pharmaceutical and biotechnology industries. Specifically, NIH invests resources in every state and in 90% of congressional districts. Further, the typical NIH grant supports seven (7) full-time or part-time jobs. (McGarvey, W.E., Morris, P., et al 2008).

Department of Veterans Affairs Medical and Prosthetic Research (VA)

The VA provides patient care and federal benefits to veterans and their dependents. Although the primary purpose of the VA health care system is quality care to qualified veterans, VA medical research contributes greatly to our overall medical research effort and patient care. Specifically, the VA's Medical and Prosthetic Research program supports heart and stroke research, so the association advocates for increased federal funding for this initiative. The VA's support for heart and stroke research makes up a small but important portion of federal research in this area. VA heart and stroke research is largely clinical, playing a unique role by immediately translating research findings into patient care.

Agency for Healthcare Research and Quality

The AHRQ develops scientific evidence to improve health care for Americans, AHRQ provides patients and caregivers with valuable scientific evidence to make the right health care decisions. AHRQ's research also enhances quality and efficiency of health care, providing the basis for protocols that prevent medical errors and reduce hospital-acquired infections, and improve patient confidence, experiences, and outcomes. To reduce disability and death from heart disease and stroke, the Association advocates for increased federal funding for AHRQ.

Centers for Disease Control and Prevention (CDC)

The CDC, based in Atlanta, GA works to protect public health and safety by providing information, and conducting surveillance and programming to enhance health decisions, and promote health through partnerships with state health departments and other organizations. The CDC focuses national attention on developing and applying disease prevention and control, environmental health, occupational safety and health, health promotion, prevention and education. The American Heart Association works closely with CDC across several areas and advocates for funding for CDC and its initiatives. The CDC remains under-funded to fully achieve its mission in cardiovascular health—prevention of risk factors, detection and treatment of risk factors, early identification and treatment of heart attacks and strokes, and prevention of recurrent cardiovascular events—with unfulfilled potential to translate knowledge into public health practice through policy/environmental/system change and to evaluate the impact of these changes on improved cardiovascular health of the nation. The Association advocates for increase federal and state funding for CDC's work, supporting activities focused on surveillance, chronic disease prevention, school-based health, and population-based prevention. The Association strives to decrease the percentage of people at risk for heart disease, stroke and other cardiovascular diseases that effectively reduce the risk factors to goal levels established by the Association's guidelines for primary and secondary prevention. In particular, the Association is focused on federal funding for the Division for Heart Disease and Stroke Prevention, which includes funding for surveillance, evaluation, research, the state Heart Disease and Stroke Prevention Program and WISEWOMAN. The Association works to secure and protect dedicated state appropriations for state Heart Disease and Stroke Prevention Programs in state health

departments. Other areas are the tobacco cessation and prevention work within the Office of Smoking and Health, and obesity prevention, nutrition, and physical activity grants, surveillance and programming within the Division of Adolescent and School Health.

Food and Drug Administration (FDA)

The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security for several important areas including human drugs, biological products, medical devices, the nation's food supply, and most recently the regulation of tobacco. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable; and helping the public get accurate, science-based information to use medicines and foods to improve health. The AHA supports increased funding for the FDA to achieve its far-reaching mission and also supports and tracks the research conducted by the agency in the areas of food labeling, devices, pharmaceuticals, consumer awareness, and tobacco marketing and advertising. The AHA encourages cross-institutional funding of appropriate research programs.

State Agencies

Public funding for research and prevention efforts at the state level is essential if AHA is to achieve its health impact goals. The AHA promotes public funding for heart disease and stroke prevention programs, securing and protecting dedicated state appropriations for Heart Disease and Stroke Prevention programs in state health departments. In those states without Heart Disease and Stroke Prevention Programs, the AHA tries to secure the establishment of new programs, which have priorities consistent with those of the CDC's National Heart Disease and Stroke Prevention program, and works to secure dedicated state appropriations to support program implementation. We have expanded our work in this area to include advocating for state and local funding for agencies outside of the Heart Disease and Stroke Prevention Programs. The expansion has allowed us to work for funding within state and local departments around obesity prevention initiatives, emergency medical dispatch and acute treatment issues as well as surveillance enhancements. The AHA routinely explores opportunities to generate and direct additional fiscal resources for these programs and initiatives and supports efforts to leverage new and existing federal funds and grant opportunities to supplement these efforts as well as other public health initiatives.

Remove Barriers to Medical Research

Over the years, medical research has faced various barriers, including proposed constraints on animal research, peak and valley funding and undue constraints within the Institutional Review Board processes and HIPPA regulations and removal of insurance barriers to patients' participation in research. The AHA advocates on several of these issues to limit the following barriers to effective medical research.

Animal Research Constraints

A small group of extreme animal-rights activists will not rest until all animal research is banned. For example, after more than a decade, these activists were successful in banning the use of U.S. Department of Agriculture licensed and regulated Class B dealers as a source of non-purpose bred dogs and cats in medical research for NIH grant recipients, beginning in 2015. In addition, they strive to discourage pounds from providing unwanted animals for medical research. They wanted to end Class B dealers based on an erroneous assumption that these dealers routinely sell abused or stolen animals to scientific laboratories. . Prohibition of the use of these Class B dealers would jeopardize cardiovascular disease research because certain studies and training to fight this condition are best performed on dogs that are large in size, older and represent a genetically diverse population. In many areas, suitable animals of these types are only available from Class B dealers. To fill this void, NIH is working to increase the capacity of Class A vendors to supply the types of dogs that currently come from Class B random source dealers. The association wants to ensure that suitable animals required for all types of medical research will be accessible and affordable.

Peak and Valley Funding for the NIH

Historically, the NIH budget has grown on average 8 percent a year. However, from 1998 to 2003, the NIH budget was doubled. Since 2003, the NIH budget has grown at an average annual rate of 1.6 percent (far lower than the national growth rate of biomedical research inflation of 2.9 percent. (Congressional Research Service 2011) In addition, last year, the NIH funded fewer grants than in the last nine years and the average grant success rate (20.6 percent) was the second lowest since 2000. (Scientists.com). The failure of the Joint Select Committee on Deficit Reduction to come up with a plan to reduce \$1.2 trillion from the national deficit means that automatic across-the-board spending cuts will go into effect in January 2013 to achieve these savings required by

the Budget Control Act of 2011. This means that nearly every federal program, including the NIH, will be cut by more than 9 percent in just one year. Cuts of this magnitude will have a devastating effect on the NIH, reducing their budget to its 2004 funding level and jeopardizing heart and stroke research and our country's status as the world leader in biomedical research. Under this scenario, the NIH budget would be slashed by nearly \$3 billion. The budget caps imposed in the 2011 Budget Control Act for FY 2013, which freeze overall discretionary spending, could result in even deeper cuts for the NIH. The association has been working with our coalitions to garner support to attempt to protect the NIH from this across-the-board cut.

A Disproportionate Lack of NIH Funding for Heart and Stroke Research

Despite considerable progress, heart disease, stroke and other forms of cardiovascular disease remain major causes of permanent disability and our Nation's No. 1 and most costly killer, with a death every 38 seconds. In the face of these staggering statistics, heart disease and stroke research remains woefully underfunded. For example, NIH invests only 4.5 percent of its budget on heart research and a mere 1 percent on stroke research. This level of funding falls far short of being commensurate with scientific opportunities, the number afflicted and the human and economic toll exacted on our Nation.

Institutional Review Board Processes/HIPAA Regulations

Institutional Review Board processes and HIPAA privacy rules do create patient and research participant confusion, inhibit recruitment of research subjects and impose costly administrative procedures. (2008) Research conducted by the AHA has shown that respondents felt their research was -impacted by HIPAA, public trust in research is not enhanced and others said the -research enterprise is damaged—specifically 49% of respondents said recruitment is decreased, 67% said submissions are more complex, 78% said costs are increased and 79% said studies are longer. Additional research from AHA has shown that potential subjects were overwhelmed with minutiae to the point where the aim of the study was lost in "necessary text" making a full reading of the form nearly impossible for patients. This in turn discouraged many patients from participating in clinical research; and some researchers noted that it is often difficult to get busy clinicians to make contact with families to ask them "permission" for a third party to contact them about research. AHA research also found that current process requirements lead to more administrative costs including additional staff and/or increased number of meetings with legal, compliance, administration, to discuss roles, business relationships, and procedures that need to be followed; and delays now inherent in IRB review and re-review nearly ensure delays unacceptable to funding agencies.

PROMOTING CARDIOVASCULAR HEALTH

In striving to achieve its mission, the American Heart Association is dedicated to promoting the cardiovascular and cerebrovascular health of the entire United States population. This requires an expansion of our advocacy and policy efforts in the areas of prevention with an emphasis on population-based and community-level interventions driven by state and federal legislation and regulation. AHA's policy efforts are grounded by science and AHA staff members are guided by the evidence base that imparts credibility for the Association's advocacy work. In some cases, the AHA will support pilot or demonstration projects to determine the efficacy of particular policy solutions. This section will address several areas of the Association's advocacy/policy agenda intent on promoting and improving health factors for all Americans including obesity, nutrition, physical activity, tobacco cessation and prevention, and air pollution. (Please see Appendix A for a summary of our policy goals as they relate specifically to the AHA's 2020 goals around cardiovascular health.)

The Impact of Environment and Policy Change

The conceptual framework for the AHA's policy work in the area of cardiovascular health is the social-ecological model which maintains that an individual's behavior is influenced by his or her surrounding physical, social, and cultural environments. (Eriksen 2005) In other words, policy makes the greatest impact when it optimizes the environments in which people live, work, learn, and play, making healthier behaviors and healthier choices the norm, putting individual behavior in the context of multiple-level influences. The ecological model represents a shift away from prioritizing individual behavior change that focuses on individual-level or intrapersonal influences. For example, comprehensive clean indoor air laws, raising tobacco excise taxes, or removing sodium from the food supply have significant immediate impact on a large segment of the population and contribute to marked improvements in cardiovascular health. These population-based strategies are a critical compliment to preventive

services and treatment programs where practitioners and patients are working together to foster important individual behavior and lifestyle changes. (Kumanyika, Obarzanek et al. 2008)

Communities are beginning to understand the importance of environment and policy change to facilitate healthy eating and physical activity, to minimize tobacco use, and address obesity. The Institute of Medicine, backed by studies from around the world, recently published a report showing reduced incidence of acute myocardial infarction after implementation of clean indoor air laws in workplaces and communities. (IOM 2009) Three recent landmark reports have highlighted policy strategies at the community level to address cardiovascular health targeting community leaders, policy makers, and organizations focusing on a huge range of policy options including access and affordability of healthy foods, opportunities for active living through the built environment, increasing consumer knowledge with approaches like menu labeling in restaurants, and strengthening nutrition standards and physical education/physical activity opportunities in schools for children. (2009),(2009),(2009) The American Heart Association originally published its community prevention guidelines in 2003 highlighting many of these same recommendations and will be updating the manuscript in 2010, adding to the substantive literature and consensus in this area. (Pearson, Bazzarre et al. 2003) A recent report by Trust for America's Health showed that an investment of \$10 per person per year in proven community-based prevention programs could save the country more than \$16 billion annually within five years. (2008)

Ethnic Disparities/Vulnerable Populations (See Appendix B)

Lower socioeconomic status and educational attainment are established risk factors for CVD and stroke. (2009) Additionally, the obesity epidemic and risk factors for cardiovascular disease and stroke such as smoking, physical inactivity, hypertension and diabetes are disproportionately prevalent in non-Hispanic blacks, American Indians, Alaskan natives, the Hispanic/Latino population, Native Hawaiians, and Pacific Islanders compared with non-Hispanic whites. (Lloyd-Jones, Adams et al. 2009) Children also comprise a vulnerable population and their health statistics are worsening. (Zerhouni 2006) If the American Heart Association is to achieve its 2020 goals to reduce death and disability from cardiovascular disease and stroke by 20% and improve the cardiovascular health of all Americans by 20%, policy work will have to prioritize opportunities to address social inequities, issues specific to vulnerable populations (ethnic and racial minorities, those with low income or less education, children, blue collar workers) and the importance of removing barriers and obstacles for risk reduction and behavior change. Often the most disadvantaged members of the population have the greatest need for preventive screenings, health promotion, or programming and have the least access or are the most reluctant to participate in these opportunities. (Lewis, Huebner et al. 1996) The fundamental causes of vulnerability are rooted in issues of daily life, most often beyond the scope of traditional public health so it will be important for the AHA to consider engaging with nontraditional partners to consider ways to reduce health disparities in communities. (Frohlich and Potvin 2008) Additional research is needed to determine how best to reach and engage underserved populations and optimize policy interventions for people of all races, age, ethnicities, educational attainment, and income levels.

Addressing Cardiovascular Health within the Context of other Global Issues

The obesity epidemic in the United States is such a profound public health concern that solutions will have to be broad-ranging and multi-faceted. Many of the causes of the obesity epidemic are due to entrenched behaviors and practices throughout modern society. In addition to prioritizing typical areas in the health domain, the American Heart Association will have to consider uncharted areas of policy development such as transportation, climate control, the green movement, poverty, labor issues, economic development, national security or community revitalization to take advantage of opportunities as they arise. The AHA will continue to foster the idea of -health in all policies and show a willingness to collaborate with non-traditional partners to find solutions, often requiring significant education and awareness building. Outside the health arena there are other more prominent factors that drive change, so research is needed to demonstrate benefits to society beyond public health.

Fossil Fuel Consumption, Greenhouse Gas Emissions and Transportation Policy

The United States is a car-centered society for many reasons—a reduction in costs to own, insure, and fuel vehicles, convenience, fear of crime, commuting, and community designs that discourage walking, cycling, or use of public transportation, all leading to a concomitant decline active transport. (2007) The transportation sector is the only sector for which CO₂ emissions have been steadily increasing since 1970. (2007) The decline of exercise with less active travel because of the overuse of cars leads to small energy imbalances each day that accumulate throughout the year and contribute to weight gain. Whereas, opportunities to increase active living

such as biking or walking to work are positively associated with fitness and inversely associated with BMI, obesity, triglyceride levels, blood pressure and insulin levels. (Gordon-Larsen, Boone-Heinonen et al. 2009)

Obesity requires greater use of fossil fuels. (Edwards and Roberts 2009) One study calculated that the United States uses an additional 1 billion gallons of fuel each year due to passenger overweight and obesity, accounting for up to .8% of the nation's annual fuel consumption and causing 20 billion pounds or more of carbon dioxide emissions. (Jacobson 2006; Jacobson 2009) More than 39 million gallons of fuel are estimated to be used annually for each additional pound of average passenger weight. (Jacobson 2009) Additionally, because food production is a major contributor to global warming, a leaner population consuming more foods grown locally will produce fewer greenhouse gases than a population that is obese and purchases foods transported over larger distances. (Jacobson 2006)

The same link between economic, health and environmental effects exists with air travel. Using data from the U.S. Department of Transportation researchers estimated that the American weight gain over the last decade required the consumption of an additional 350 million gallons of jet fuel just in the year 2000, roughly 2.4% of the total volume of jet fuel consumed in domestic travel that year adding \$275 million in costs for the airlines, and leading to an additional 3.8 million tons of CO₂ emissions and other particulate matter. (Dannenbergh, Burton et al. 2004)

Idling school buses emit tons of exhaust into the air each day, impacting air quality and raising the risk for cardiovascular disease and respiratory diseases such as asthma. (Brook, Franklin et al. 2004) In New York City, idling vehicles churn out as much pollution as nine million diesel trucks driving from Bronx to Staten Island and the city's laws requiring buses to shut down their engines in school zones are poorly enforced. (Israel 2009) Creating more opportunities for children to walk and bike to school would diminish the number of school buses running each day and would improve air quality and increase physical activity for American children.

Community/Economic Development

Urban and community planning are important areas for public health advocacy. Several studies have found that the way communities are designed and developed impacts access to healthy foods and physical activity opportunities and correlates with obesity. Youth whose schools are located near a fast food outlet eat fewer fruits and vegetables, drink more soda and are more likely to be obese than students at other schools. (Davis and Carpenter 2009) There is a disparate prevalence of urban corner stores in low-income and high-minority communities and purchases from these stores contribute significantly to higher energy intake and consumption of less healthy foods and beverages by urban school children. (Borradaile, Sherman et al. 2009) Projects such as farmers' markets, community gardens, promotion of culturally specific foods for ethnic minorities and Native Americans, local food production and promotion, youth agricultural and culinary training programs are all important means to address healthy food access, affordability, and behavior choices in communities. Better neighborhood resources such as safe sidewalks, green spaces, parks, public transportation, and ready access to fruits and vegetables leads to as much as 38% less risk for developing diabetes when these communities are compared with those that do not have these resources. (Auchincloss, Diez Roux et al. 2009)

Cities across the United States are debating the best ways to convert vacant lots or brown fields within the context of economic development. Community gardens, small parks, and open green spaces are excellent options for these areas. Cities need to find ways to finance their development and maintenance. Studies have shown that community gardens positively impact surrounding residential properties, increase rates of home ownership and spur economic redevelopment. (Been 2007) Other studies have shown the direct cost-benefit of building bike/pedestrian trails by reducing health care costs associated with physical inactivity. For every dollar invested in building these trails, nearly \$3 in medical cost savings may be achieved. (Wang, Macera et al. 2005) Additionally, linking different parts of the community with trails and walkways opens up the opportunity for community integration, more efficient land use, lower traffic congestion, and better quality of life.

National Security/Military Recruitment/Emergency Response

The obesity epidemic and fitness levels of the U.S. population are impacting military recruitment, and the numbers of men and women who may be able to qualify for enrollment at police academies or pass fitness tests given to emergency responders or military personnel. (2005) One recent study released by the generals and admirals of Mission: Readiness revealed that 75% of young Americans are unable to serve in the military because they have either failed to graduate high school, engaged in criminal activity, or are physically or mentally unfit. (2005) According to the Army, very few soldiers enter the military physically fit, and so the services rely heavily on their

basic training system to provide effective physical fitness training. (2006) For these same reasons, obesity prevalence is impacting recruitment to police academies and potential effectiveness of emergency response. Ultimately, this has ramifications for U.S. national security. It will be important for the AHA to underscore this point in its policy/advocacy work to create an important rationale for policy-makers to incorporate obesity prevention policy throughout the different levels of government in a coordinated way.

Summary

All of these examples emphasize the fact that lowering the body mass index (BMI) in the U.S. population, making our communities tobacco-free, improving access and affordability of healthy foods, increasing opportunities for physical activity, and designing our communities, workplaces, and schools for active living would have significant impact not only on cardiovascular health and mortality from heart disease and stroke, but also on food energy, fuel costs, air pollution, transportation policy, national security, labor laws, poverty, greenhouse gas emissions, highlighting some non-traditional areas of policy the AHA might take advantage of to achieve its strategic policy goals. Potentially, AHA will be able to connect its work in public health to other areas of global concern.

The AHA's Policy Agenda to Address Cardiovascular Health

Obesity

Currently, the United States is in the midst of a full-blown obesity epidemic. The prevalence of those who are obese has risen to 33.9%. (Lloyd-Jones, Adams et al. 2009) In 2011, adult obesity rates grew in 16 states, in more than two-thirds of states, obesity rates exceed 25 % of all adults, and 12 states have obesity rates greater than 30%. (Foundation 2011) According to the WHO, the number of overweight and obese people world-wide is set to increase to 2-3 billion by 2015 if current trends continue. (Lloyd-Jones, Adams et al. 2009)

These rates bode poorly for health outcomes. A 2003 study showed that by age 40, a non-smoking obese woman loses 7.1 years of life expectancy and a non-smoking obese man loses 5.8 years. (Peeters, Barendregt et al. 2003) Severely obese individuals lose 8-10 years of life expectancy, which is comparable to the effects of smoking. (Whitlock, Lewington et al. 2009) Of greatest concern, the obesity epidemic is spreading to our nation's children at an alarming rate. Nearly 10 million children and adolescents ages 6-19 are considered overweight. (Lloyd-Jones, Adams et al. 2009) Sadly, recent research shows that obese children's arteries resemble those of a middle-aged adult. (Le, Zhang et al.) Overweight adolescents have an overwhelming chance of becoming obese adults and they are being sentenced to an early future of cardiovascular disease and disability. (Baker, Olsen et al. 2007)

In line with prevalence, the economic costs of obesity continue to grow. In 1998, medical costs were estimated at \$78.5 billion with approximately half financed by Medicaid and Medicare; by 2008, those estimated costs rose to \$147 billion. (Finkelstein, Trogdon et al. 2009)

The AHA supports the following priorities to address obesity in a comprehensive way:

Obesity diagnosis, prevention, and treatment in the healthcare environment

The AHA acknowledges that addressing overweight and obesity in healthcare is a critical part of reversing obesity rates across the United States in adults and children. The evidence base concerning appropriate treatment and prevention options is still evolving. However, current evidence provides guidance on effective practice, assessment, diagnosis, and treatment. Areas of priority include assessment of BMI at all primary care visits, appropriate follow-up and treatment for those at risk or who are already obese, adequate reimbursement for providers to address and treat obesity, continuing research on effective clinical strategies to achieve and maintain weight loss, and effective training and professional development for medical professionals. The prevention and treatment of obesity will pay dividends in reducing cardiovascular disease, stroke and disability, averting healthcare costs and avoiding the negative impact of productivity in the workforce. Providers play a key role in the fight against obesity and need to be given the support and training necessary to be effective in the clinical environment and be passionate advocates in their communities.

Adequate surveillance and monitoring

In order to assess the impact of policy interventions and the success of programming on prevalence of obesity, diabetes, physical inactivity, nutritional status, and health behaviors it is critical that the United States conduct comprehensive surveillance, monitoring, and evaluation. Larger sample sizes of children and adolescents and of

minority populations, as well as state-based samples, are needed to provide adequate data for policy development and monitoring of cardiovascular health. The AHA advocates for incorporating more robust measures in current surveillance programs such as the National Health and Nutrition Examination Survey (NHANES), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavioral Surveillance System (YRBSS), School Health Policies and Programs Study (SHPPS) Surveillance and others, and also obtaining adequate funding for these programs. (Goff, Brass et al. 2007) Areas for improved surveillance or continued robust assessment would be body mass index, adiposity, physical fitness, sodium consumption patterns and sodium reduction in the food supply, trans fat, saturated fat, hypertension (prevention, prevalence, and control), tobacco use, dyslipidemia, and dietary patterns.

Comprehensive worksite wellness

With more than 130 million Americans employed across the United States, workplaces provide a large audience for cardiovascular disease (CVD) and stroke prevention activities. Experience has shown that workplace wellness programs are an important strategy to prevent the major shared risk factors for cardiovascular disease and stroke including cigarette smoking, obesity, hypertension, dyslipidemia, physical inactivity, and diabetes. The American Heart Association advocates for comprehensive worksite wellness programs that include tobacco cessation and prevention, regular physical activity, stress management/reduction, early detection/screening, nutrition education and promotion, weight management, disease management, cardiovascular disease education including cardiopulmonary resuscitation (CPR) and Automated External Defibrillator (AED) training, and changes in the work environment to encourage healthy behaviors and promote occupational safety and health. (Carnethon, Whitsel et al. 2009) The AHA supports grants and tax incentives to employers who provide comprehensive worksite programs. Employers should adhere to all regulations that address hazards to employee health and safety, providing working conditions that are optimal for cardiovascular health and well-being. Employers who choose to offer healthy lifestyle behavior incentives in the workplace, such as wellness credits and financial incentives, should provide these directly to the employee. Financial incentives should not be attached to healthcare premiums or health status or contingent upon answering intrusive questions.

School local wellness policies

The AHA will advocate for comprehensive school local wellness policies that include nutrition standards, nutrition education/promotion, physical activity/physical education, and food marketing and advertising with a priority on transparency, effective and timely implementation, and robust monitoring/evaluation, leading to regular review and revision. The AHA supports the development of wellness councils at each school and at the district level that meet regularly and have the appropriate representation of school administrators, teachers, parents, school food service personnel, students, members of the community, and health professionals.

Coordinated School Health

The AHA supports increased funding and development of coordinated school health programs, integrating priorities around nutrition, physical activity, health and physical education and obesity prevention throughout the school day.

Early childhood education

The American Heart Association advocates for strong health promotion and obesity prevention programs in early childhood programs. Child care settings are an important environment for forming good health habits around children's dietary intake, physical activity, and energy balance and thus combating the childhood obesity epidemic. (Kumanyika 2008) The 2005 National Household Education Survey reports that 74% of all US children aged 3 to 6 years not yet in kindergarten were in some form of non-parental care, and 57% were in a center-based child care program making this an ideal setting for obesity-prevention interventions targeting this age group. (2008) Furthermore, it has been reported that many children from low-income backgrounds consume 50% to 100% of their Recommended Dietary Allowances in a child care setting and many children spend the majority of their waking hours out-of-home. (2007) In the federal Head Start program alone there are more than 1 million children and 200,000 staff members across the United States, not to mention the multitudes of children from infancy to age 5 who are in private and public day care and preschool programs. Children are spending many waking hours in these programs and they should be safe, healthy, and smoke-free environments. Reaching young children and their families is an essential strategy for primary prevention of cardiovascular disease and associated risk factors.

Ongoing research

The AHA will continue to support ongoing research to continue to evaluate effective measures to treat, prevent, and diagnose obesity, help people eat healthy foods, and spur the population toward greater levels of physical activity and less sedentary behavior.

Nutrition

Improve access to and affordability of healthy foods

The AHA supports healthy food retailing initiatives, such as grants, loan financing, and tax subsidies for the development of healthy food retailing in underserved rural, urban, and suburban communities. Helping fresh food retailers overcome the high initial barriers to entry into these underserved areas includes pre-development costs, energy efficiency upgrades, worker training and land acquisition and construction; renovation and expansion of existing stores; and innovations in healthy food retailing. (Ver Ploeg 2009) These programs can create jobs, stimulate the local economy, attract investment in underserved, low-income communities, support innovation in healthy food retailing, and impact the health of families and children. The AHA also: encourages the development of farmer's markets, farm-to-school programs, and community gardens; encourages addressing the issue of food economics so that healthy alternatives are less expensive and nutritionally-low food costs more, bringing subsidies, incentive, and other pricing strategies more in line with AHA's Diet and Lifestyle Recommendations and the Dietary Guidelines for Americans; (Lichtenstein, Appel et al. 2006) (2005) and supports laws and regulations that encourage the availability, affordability, and appropriate distribution of fruits, vegetables, fiber-rich whole grains, fish (especially fatty fish) and low-fat dairy products.

Strengthen nutrition standards in schools for meals and competitive foods and in all government nutrition assistance or feeding programs

- The American Heart Association supports state and federal legislation and regulation that addresses nutrition standards for competitive foods and beverages in schools that are at least as strong as the beverage, snack, and reimbursable meal guidelines for the Alliance for a Healthier Generation Healthy Schools program. These standards as well as those from the Institute of Medicine (2007) offer science-based nutritional guidelines that will help schools promote children's consumption of a healthy, balanced diet: with fiber-rich whole grains, fruits and vegetables, fish (especially fatty fish) and low-fat and fat-free dairy products; and with limited intake of industrially-produced trans fats, added sugar, salt and calories. The AHA also supports the recently released IOM Guidelines (2009) for the school meal programs and will work with Congress and the USDA to assure these standards are implemented quickly and effectively. The AHA will advocate for strong nutrition standards for all persons who receive assistance, food or meals through government nutrition or feeding programs.

Improve food labeling to help consumers make healthy point-of-purchase decisions that ultimately lead to healthy food and beverage consumption patterns in the U.S. population

- The AHA ultimately favors the establishment by the FDA of a directed, standardized, comprehensive front-of-package food labeling program and icon system with unified criteria based upon the best available science and consumer research, featuring consumer education as a primary goal of front-of-package food labeling;
- The AHA will inform the regulatory process regarding revision of the Nutrition Facts Panel including issues such as trans fat, added sugar, sodium, fiber-rich whole grains, and the way the label is organized and graphically presented to optimize consumer understanding as well as position itself to respond to all important emerging food labeling issues.

Menu labeling in restaurants

- The American Heart Association supports providing calorie information on menus and menu boards at point-of-purchase with additional information regarding sodium, saturated fat, trans fat, and other nutrients available in the restaurant upon request. The ultimate goal is to provide this information in all restaurants. In tandem with this recommendation, the American Heart Association supports the development and implementation of a consumer education campaign to help people –know their energy needs for recommended daily calorie intake and food and beverage serving sizes.

Reduce sodium in the food supply

- The AHA will play a leading role in reducing sodium in the food supply. The AHA will continue its advocacy efforts to reduce Dietary Recommendations for sodium intake in American's diets, streamline and optimize food labeling to help educate consumers about sodium, support appropriate procurement policies, restaurant labeling, promote education and awareness campaigns, and enhance U.S.

surveillance/monitoring of sodium intake to understand the effectiveness of national and statewide interventions.

Continue advocating for the removal of industrially-produced trans fats from the food supply and assure that there isn't a rise in unhealthy replacement fats/oils and concomitant increase in saturated fat consumption

The American Heart Association (AHA) supports regulatory and legislative efforts to reduce trans (partially-hydrogenated) fats in the food supply, including foods available in restaurants, school meal programs and government feeding programs. The availability of healthy alternatives (including subsidizing the production of trans-fat free oils), practical guidance around food preparation, and education to consumers, school food service personnel and the restaurant industry should be incorporated into advocacy efforts. The AHA will continue to monitor any subsequent increase in palm oil and saturated fat as partially-hydrogenated oils are removed.

Food marketing and advertising to children

The AHA believes Congress should restore to the Federal Trade Commission (FTC) and the Federal Communications Commission (FCC) the ability to regulate marketing of foods and beverages to children. AHA supports the Interagency Work Group on Food Marketed to Children to release the voluntary guidelines on food marketed to children as mandated by Congress and based on the latest evidence. The AHA would also support other measures that restrict food advertising and marketing to children including, but not limited to allowing only healthy foods to be marketed and advertised to children, discouraging the product placement of food brands in all of the different media/technology platforms, eliminating the use of toys in unhealthy kids' restaurant meals, using licensed characters only on healthy foods, and not allowing food and beverage advertising and marketing in schools or on educational materials. The AHA also supports the development of a unified set of nutrition standards to guide manufacturers on the types of foods they can market and advertise to children age 12 and under.

Nutrition education/promotion in schools

Nutrition education should be integrated throughout the school curriculum and integrated with foods sold in the cafeteria. Nutrition promotion throughout the school setting is a priority.

Procurement standards for foods purchased by employers and government agencies The AHA will work to strengthen the procurement standards that have been written for and adopted by the federal agencies, especially since they will be the basis for many state and local efforts around procurement standards.

Added sugar in the food supply

As a follow-up to the AHA's recent scientific statement on dietary sugars and cardiovascular health, (Johnson, Appel et al. 2009) the AHA will continue to advocate for reducing the amount of added sugar in the food supply and advocate that added sugar be included directly on the Nutrition Panel.

Advocate for robust surveillance to monitor food composition, food intake, and biologic markers of nutrition important for cardiovascular health

Physical Activity

Regular moderate-vigorous physical activity leading to physical fitness has numerous health benefits, including a 30-50% reduction in cardiovascular disease that is commensurate with not smoking. (Mora, Cook et al. 2007) Additionally, physical inactivity and sedentary behavior are an independent risk factor for chronic diseases and lead to coronary heart disease, obesity, diabetes, hypertension, dyslipidemia, certain cancers, and some mental disorders such as depression. (2006) One study demonstrated medical costs of physical inactivity at \$76.6 billion per year (Pratt, Macera et al. 2000) and another calculated that the United States would save \$5.6 billion from the cost of coronary heart disease alone if 10% of adults began a regular walking program. (Jones and Eaton 1994) Increasing opportunities for active living in communities has been linked to greater physical activity in the population. (2009) Despite the health benefits of regular physical activity, potential medical cost savings, and positive impact on quality of life, less than 10% of U.S. adults are getting the recommended amount of moderate-vigorous physical each day and less than 50% of children are getting their daily recommended dose. (2007) (Haskell, Lee et al. 2007) (2005) (Troiano, Berrigan et al. 2008)

The Physical Activity Guidelines for Americans (2008) recommend that adults should do at least 2½ hours of moderate intensity exercise per week or 75 minutes of vigorous intensity performed in bouts of at least 10

minutes, preferably spread throughout the week. Additional benefit comes with more exercise. Adults also should do resistance training involving all major muscle groups at least twice per week. Children and adolescents should do at least 1 hour of moderate-vigorous physical activity every day and muscle-strengthening and bone-strengthening exercises at least three days per week.

In its advocacy work, the AHA will prioritize policies that will help the U.S. population reach these goals, creating active living and physical activity opportunities in worksites, schools, and communities and promoting quality physical education. AHA priorities in the area of physical activity policy include:

Support efforts to design our workplaces, communities, and schools around active living and integrate physical activity opportunities throughout the day

- The AHA supports development of regulation and legislation that allows shared use of school facilities within the community (e.g., school fields, running tracks, or fitness facilities when school is not in session);
- Fund and develop walking and biking trails that connect key aspects of the community, zoning/building ordinances that encourage walking and stair use, wider streets to allow for biking and walking, pedestrian-friendly streets and roadways with appropriate cross-walks, sidewalks, traffic lights, and, slower speed limits in walking/biking areas;
- Increase school construction and allow for some of those funds to build fitness facilities or other infrastructure to support physical activity;
- Increase consumer knowledge and promote policies around lowering car use and increasing physical activity: workplace travel plans, car-sharing, bike racks, telecommuting;
- Provide financial incentives such as grants or tax breaks to support employers who offer physical activity/exercise facilities on site, encourage active commuting, offer gym memberships, time off during the work day to exercise, create worksite policies that foster physical activity during the work day, or design workplace facilities or infrastructure to foster physical activity;
- Advocate for policies that increase recreational areas, parks, biking and walking trails or green space in community settings;
- The AHA supports a minimum of 60 minutes per day of supervised, moderate-vigorous physical activity in school including physical activity integrated into the curriculum, recess, activity periods, or other similar opportunities. Physical Education and recess should be required in all elementary schools;
- Implement and fund Safe Routes to School;
- Integrate physical activity into all early childhood programs and in before and after school programs;
- Support sports, intramurals and activity programs in schools and in the community.

Increase the quantity and improve the quality of physical education in schools

Daily quality physical education in the nation's schools is an important part of a student's comprehensive, well-rounded education program and a means of positively affecting life-long health and well-being. The optimal physical education program will foster a lifetime commitment to physical activity as part of a healthy lifestyle. Children spend over half their day in school, so it is reasonable to require that they should get at least 30 minutes of recommended physical activity in school. (Pate, Davis et al. 2006) Physical education should be an important part of that requirement and does more than provide some minutes of moderate-vigorous activity. It also teaches students how to integrate exercise into their lives in order to establish a lifetime of healthy living. Students who are physically fit may have better academic performance, school attendance, and behavior in the classroom. (Carlson, Fulton et al. 2008) (2007) (Coe, Pivarnik et al. 2006) (Castelli, Hillman et al. 2007) (Geier, Foster et al. 2007) Unfortunately, only 3.8% of elementary, 7.9% of middle, and 2.1% of high schools provide daily physical education or its equivalent for the entire school year. (2007) Twenty-two percent of schools do not require students to take any physical education at all. (2007) Strategies to improve quality physical education in our nation's schools include:

- Holding schools accountable by requiring them to report to parents and the community on the amount and quality of the physical education program being offered;
- Require all school districts to develop and implement a planned K-12 physical education curriculum that adheres to national and state standards for health and physical education, including offering 150 minutes per week of physical education in elementary school, 225 minutes per week in middle school and requiring physical education for graduation from high school;
- Hire a physical education coordinator at the state level to provide resources and offer support to school districts across the state;
- Offer regular professional development opportunities to physical education teachers that are specific to their field;

- Require certified physical education teachers, and add valid fitness, cognitive, and affective assessments in physical education that are based on student improvement and knowledge gain;
- Require that students be active in moderate-vigorous physical activity for at least 50% of physical education class time;
- Assure that physical education programs have appropriate equipment and adequate facilities;
- Require physical education for high school graduation and for promotion from one grade to the next;
- Do not allow students to opt out of physical education with waivers or substitutions or to prepare for other classes or standardized tests.

Implement the National Physical Activity Plan and Physical Activity Guidelines for Americans

The Physical Activity Guidelines for Americans were released in 2008, a landmark document for helping to promote physical activity across the U.S. population. The AHA has endorsed these national consensus guidelines and maintains that they should be regularly updated like the Dietary Guidelines for Americans. For the Guidelines to truly make their impact, it is necessary for the U.S. to have a national physical activity plan and an implementation strategy, providing a framework for a broad and comprehensive national effort to assure that the Guidelines translate into increased physical activity, actual lifestyle behavior change and risk reduction across the population.

In 2010, the National Physical Activity Plan was released. This plan provides a road map for physical activity advocacy and policy efforts over the next decade in key sectors of public health, education, transportation, urban design/community planning, business and industry, mass media, healthcare, parks, recreation, fitness and sports, and volunteer/non-profit organizations. The AHA has taken a lead role in helping to develop the plan and in implementing the national plan in coordination with the National Coalition to Promote Physical Activity.

Tobacco

Cigarette smoking remains the leading cause of preventable morbidity and premature death in the United States. (Lloyd-Jones, Adams et al. 2009) Each year, approximately 443,000 persons in the U.S. die prematurely as a result of smoking or exposure to secondhand smoke. (November 14, 2008) Second hand smoke is a carcinogen to children and adults who do not smoke. (2006) Second hand-smoke produces immediate adverse effects on heart function, blood platelets, inflammation, endothelial function and the vascular system. (Dinno and Glantz 2007) The AHA has long advocated for strong public health measures that will reduce the use of tobacco products in the United States and limit exposure to secondhand smoke. The various policies prioritized by the AHA and its national partners are the following:

Support significant increases in tobacco excise taxes.

Policymakers should seek opportunities to allocate a portion of revenues generated by increased tobacco excise taxes to tobacco control, prevention and cessation programs, as well as other health-related initiatives such as those to improve access to health care.

Establish sustainable funding for state tobacco cessation/prevention programs to levels that meet or exceed Centers for Disease Control and Prevention recommendations.

- Tobacco control programs should be comprehensive in accordance with CDC recommendations, constructed intelligently, staffed appropriately and administered effectively with periodic evaluation.

Pass and protect comprehensive smoke-free air laws

- The American Heart Association advocates for comprehensive smoke-free laws in federal buildings and at the state and local levels, in compliance with the Fundamentals of Smoke-free Workplace Laws guidelines (http://www.no-smoke.org/pdf/CIA_Fundamentals.pdf) to maximize the impact of smoke free policy efforts and increase the number of workers and residents in the United States who are protected from second hand smoke in workplaces and public places. (2008) For states with preemption, the AHA will work to remove preemption provisions and/or strengthen statewide smoke-free air laws. Estimates are that exposure to second hand smoke (also called passive smoking) causes 21,800-75,100 coronary heart disease (CHD) deaths and 38,100-128,900 myocardial infarctions (MIs) annually. (Lightwood, Coxson et al. 2009) Long-term exposure to second hand smoke, such as that occurring in a home or workplace, is associated with a 25%–30% increased risk for coronary heart disease in adult nonsmokers. (2009)

Assure comprehensive implementation of FDA regulation of tobacco and learn from the data gathered during the regulatory process to continue to improve upon tobacco control efforts in the U.S.

- The signing of the Family Smoking Prevention and Tobacco Control Act by President Obama in 2009 was a landmark achievement toward further reducing the death and disease from tobacco. The Food and Drug Administration now has the tools and jurisdiction to reign in the tobacco industry. The AHA will continue to work with the FDA tobacco center and support and monitor its efforts as it exercises its new authority to prohibit marketing and advertising targeting youth, ban misleading claims, and regulate the manufacture of tobacco products in the interests of public health.

“Harm reduction”/Smokeless tobacco products

With passage of FDA regulation of tobacco and clean indoor air laws, the tobacco industry has responded with a plethora of products that are an alternative to traditional cigarette smoking. As a national non-profit health organization committed to accelerating tobacco control research and policy efforts, the American Heart Association does not recognize these products as a safe alternative to cigarettes or as smoking cessation products. AHA will work to ensure that the FDA tobacco center closely monitors and scrutinizes actual and implied health claims.

Advocate for comprehensive smoking cessation benefits in Medicare, Medicaid and private health plans

The AHA advocates for access to universal smoking cessation benefits to all smokers. The combination of prescription drug therapy and counseling to assist in stopping tobacco use is recognized as both effective and economical. AHA will work to remove barriers to access and promote the utilization of cessation programs. Research is needed to compare the effectiveness of different treatments, how this may vary for different populations and continue to conduct cost/benefit analyses..

Promote policies that reduce the advertising and sale of tobacco products

The tobacco industry continues to find ways to promote tobacco products to young people. The Association supports policies that limit advertising directed to youth and increase barriers to youth purchasing tobacco.

Tobacco sales in pharmacies and other health-related institutions

The AHA advocates banning tobacco sales in health care institutions including pharmacies. It is incongruent to place tobacco products right near tobacco cessation aids and in places where promoting health is the foremost purpose. Removing tobacco products from these institutions and businesses is another step in AHA’s longstanding efforts to de-normalize tobacco products.

Air Pollution

The American Heart Association maintains that exposure to particulate matter air pollution is a modifiable risk factor that contributes to cardiovascular morbidity and mortality. (Brook, Franklin et al. 2004) Long-term exposures can increase risk and a reduction in air pollution can lower the risk of developing cardiovascular disease. For this reason, the AHA will:

Monitor opportunities to influence legislation and regulation at the state and federal level to decrease the amount of particulate matter air pollution from various sources.

SUPPORT HIGH QUALITY/HIGH VALUE HEART DISEASE AND STROKE CARE

In its landmark report, Crossing the Quality Chasm, the Institute of Medicine (IOM) declared that, -Between the health care we have and the care we could have, lays not just a gap, but a chasm. (2001) In fact, Americans only receive the recommended care approximately half of the time. (McGlynn, Asch et al. 2003)

The standard set by the IOM is a recommendation that people should receive the care they need and need the care they receive. Health care must be safe, effective, patient-centered, timely, effective and equitable. (2001) Policymakers, academics and advocates committed to high-quality health care have been working to move the health care delivery system closer to these goals.

Deficits in quality have been found across the care continuum. For example, RAND’s 2003 national study on health care quality found that:

- recommended care for managing chronic conditions (e.g., diabetes and hypertension) was provided only 56 percent of the time;
- preventive care (e.g., flu shots, mammograms and smoking cessation counseling) met quality standards only 55 percent of the time; and
- recommended care for acute health problems (e.g., pneumonia and urinary tract infections) was provided only 54 percent of the time. (McGlynn, Asch et al. 2003)

Particularly troubling for advocates seeking to reduce unnecessary death and disability from cardiovascular disease and stroke, the RAND study reported the following:

- people with diabetes received only 45 percent of the care they needed;
- in the two-year study, blood sugar was not measured in 40 percent of patients with diabetes;
- one-quarter of those with their blood sugar measured demonstrated poor control, which can lead to kidney failure, blindness, and amputation of limbs;
- patients with hypertension received less than 65 percent of recommended care; and
- although people with coronary artery disease received 68 percent of recommended care, just 45 percent of heart attack patients received beta blockers and 61 percent got aspirin. (McGlynn, Asch et al. 2003)

This section provides an overview of the AHA's public policy approach to improving health care quality. It includes a summary of the current federal health reform agenda as it relates to health care quality. Finally, it specifically addresses health care quality, as well as the role of health care quality in developing and using cardiovascular and stroke drugs, treatments and devices.

Improving Health Care Quality

To improve health care quality, leading scientific organizations committed to evidence-based medicine like the American Heart Association develop clinical practice guidelines that translate clinical evidence into specific written recommendations to inform health care providers' and patients' decision-making. The Association integrates these practice guidelines into continuous quality improvement tools for both health care providers and consumers to use when evaluating their health care choices. The increasing sophistication of these tools and the pace of advances in health information technology offer significant promise for improving informed clinical decision-making.

To leverage its own work and enhance policymakers' focus on strategies to improve health care quality, the Association supports the following public policies goals:

Improve and better evaluate the quality of care delivered and also the impact of measures designed to improve quality and therefore outcomes

- The Association supports public policies that encourage the development and implementation of health information tools, such as clinical-decision-making technology that delivers clinical guidelines in real-time to clinical decision-makers. These tools aid the delivery of prompt and appropriate care and enhance adherence to clinical practice guidelines. Further, they assist education efforts to help consumers evaluate health care quality and outcomes.

Promote reporting on quality measures

- The Association supports public policies that encourage the health care community to report and assess quality through the development of performance measures that are integrated into quality improvement tools. Evaluating quality requires using measures that are risk-adjusted, standardized and evidence-based. Quality-of-care measures can help create learning environments for health care professionals and ensure that best practices are applied uniformly to all patients. The measures should be broad in scope, and include measures of patient satisfaction, access and convenience. The goal should be to promote care that is truly patient-centered and responsive to patient and caregiver needs.

Evaluate the role of quality in health care payment systems

- The Association believes that mechanisms for better aligning payment for health care services with the goal of improving health care quality should be considered. However, programs that use specific financial incentives to promote quality, known as pay-for-performance programs, should be considered carefully and should include evaluation mechanisms to assess their impact on patients and patient care. These and other potential mechanisms for financing health care reform should continue to be tested to measure the impact on outcomes and costs and to ensure that there are no unintended consequences.

- The AHA maintains that the best way to use precious healthcare resources is to practice the best medicine, avoid waste, and consider the patient's preference. Physicians need to take into account the ability of each diagnostic test to provide the most precise and useful incremental information that can assist them in determining the need for a change in therapy, as well as the risks and benefits of all the options for treatment. They should decide on a treatment that is the most effective and matches patients' preferences.

Support the expansion of health information technology (HIT)

- The Association promotes legislation and regulations that encourage the development and use of HIT with appropriate patient privacy safeguards. Well-implemented HIT can improve the quality of care and adherence to evidence-based guidelines. The Association promotes policies that empower consumers to make informed decisions regarding the importance of owning, managing and maintaining personal health records.

Support the development, implementation, evaluation, and dissemination of effective public health policies and programs to promote cardiovascular health and reduce the burden, disparities, and costs of cardiovascular diseases.

Begin to address specific issues around end-of-life care including disease management, transitional care and hospice, confronting that an overwhelming majority of lifetime health care costs are spent in the last few months of life, and creating a system where people can die with dignity and respect.

Health Care Reform

Delivering on the promise of high-quality, high-value heart disease and stroke care requires, first and foremost, a commitment to ensuring that all Americans have access to and coverage for high-quality, evidence-based health care services. To that end, the Association believes the following critical principles must be addressed if health care in the United States is to be safe, effective, patient-centered, timely, effective and equitable:

All residents of the United States should have meaningful, affordable healthcare coverage.

Preventive benefits should be an essential component of meaningful healthcare coverage, and incentives should be built into the healthcare system to promote appropriate preventive health strategies.

All residents of the United States should receive affordable, high quality health care.

Race, gender and geographic disparities in health care must be eliminated.

Support of biomedical and health services research should be a national priority and inflation-adjusted funding for the National Institutes of Health must be maintained and expanded.

The United States' healthcare workforce should continue to grow and diversify through a sustained and substantial national commitment to medical education and clinical training. (Gibbons, Jones et al. 2008)

The health reform law, the Affordable Care Act, increases the federal policy focus on improving health care quality through a variety of policy proposals,

Requiring the development of a national strategy for quality improvement.

Developing a multi-stakeholder process for the selection of quality measures to be used in payment systems.

Establishing a Center for Medicare and Medicaid Innovation within the federal Centers for Medicare and Medicaid Services to test innovative payment and service delivery models that reduce costs and improve quality.

Initiating a hospital value-based purchasing (i.e., pay-for-performance) program.

Introducing a value-based payment enhancement for physicians.

Creating a process whereby the federal Secretary of Health and Human Services would make performance information on quality measures publicly available.

Developing a Medicare program to allow providers to share in savings generated from improving health care quality.

Adopting a Medicare initiative to reduce payment to hospitals with excess hospital readmissions; and Creating a program to engage patients and caregivers in health care decision-making by sharing information about trade-offs among treatment options and focusing on patient care preferences.

Cardiovascular and Stroke Drugs, Treatments and Devices

In 2009, the total direct and indirect cost of cardiovascular diseases and stroke in the United States was estimated to be \$475.3 billion. Of these costs, \$52.3 billion in direct costs were estimated to be spent for drugs and other medical durables, second only to hospital direct costs. (Lloyd-Jones, Adams et al. 2009) Cardiovascular and stroke drugs and devices can be vital in the prevention and treatment of these conditions. However, they must be accessible and affordable to ensure that consumers can comply with appropriate treatment regimens.

The Association supports increased access to a broad range of cardiovascular disease and stroke drugs, treatments and medical devices and opposes therapeutic substitution of prescription drugs within a class. Public policy should support appropriate patient safeguards in the development and implementation of formularies. Further, drugs and devices used to treat or prevent cardiovascular disease and stroke must be properly reviewed, labeled, dispensed and marketed.

To help implement these objectives, the Association aims to:

Promote scientific oversight and patient protections for drug, treatment and medical devices

- The Association supports increased access to a broad range of heart disease and stroke drugs, treatments, and medical devices, while safeguarding patients. To this end, the Association backs a strong, scientifically-based FDA whose primary mission is promoting and protecting the public's health and safety, and believes that the FDA should be funded at the appropriate level to allow it to carry out this critical assignment.

Work with payors to evaluating payment policy's impact on patient care

- The Association works with payors such as the federal Centers for Medicare and Medicaid Services to evaluate the appropriateness of services and procedures, such as carotid artery stenting for stroke patients, anticoagulant home monitoring for patients with atrial fibrillation, or deep vein thrombosis. The Association has also helped design quality measures and incentives to improve patient care and outcomes.

Ensure transparency in health insurance benefits and associated costs

- The Association supports greater transparency as a means to empower health care consumers to better understand their share of health care costs, their current health insurance coverage and their health care coverage options. Specifically, the Association encourages public policies that would increase transparency of the costs of insurance coverage and expand consumers' health care decision-making tools.

Monitor drug formulary policy

- The Association supports policies that promote formularies that permit therapeutic interchange and generic substitution when necessary and in designated circumstances and do not allow for therapeutic substitution. The AHA continues to monitor, evaluate and promote proposed public policies concerning drug formularies.

Promote quality through adherence to clinical guidelines and treatment protocols

- The Association supports public policies that promote quality health care through adherence to evidence-based guidelines and protocols for drugs, treatments and devices, including efforts to decrease health

disparities and promote health equity. The Association focuses on identifying opportunities to promote quality through the use of evidence-based performance measures in the delivery of care.

Conducting and interpreting comparative effectiveness research according to fundamental scientific principles

- The Association supports comparative effectiveness research based on the scientific knowledge gained from the randomized clinical trials that are typically used to assess the clinical efficacy of a new therapy. It is essential, however, for patients and healthcare providers to understand research limitations when interpreting the findings of comparative effectiveness research. Comparative effectiveness research may include estimates of cost and cost-effectiveness, but comparative effectiveness research should focus on enhancing value for patients rather than minimizing costs. (Gibbons, Gardner et al. 2009)

Address the needs of caregivers for heart and stroke patients

There are numerous studies showing that caregiving is difficult, burdensome and those caregivers who experience stress have greater heart disease and mortality themselves. The AHA will consider opportunities to work with groups such as the National Alliance for Caregiving and AARP to address the needs of caregivers, and leverage efforts for heart disease and stroke patients.

Invest in a significantly expanded, nationwide caregiver support system that makes evidence based programs for caregivers widely available and easily accessible. Support legislation that provides a monthly stipend to family caregivers; offers caregiver education, training and counseling; provides oversight of caregivers including home visits; and other kinds of caregiver support.

Design a caregiver credit under the Social Security System as suggested by the General Accountability Office.

Such a credit would either: 1) allow a specified amount of caregiving time, perhaps three or four years, to count as covered employment, and assign a wage to that time; 2) exclude a limited number of caregiving years from the benefit calculation so that instead of averaging earnings over 35 years, earnings are averaged over fewer years; or 3) supplement caregivers' retired worker benefits directly, regardless of whether they took time out of the workforce for caregiving. Social Security credits should be provided to workers who leave the workforce to become unpaid caregivers.

Increased attention to health care quality, including the quality of emergency response, at both the federal- and state-levels provides opportunity for the Association to use its clinical expertise as a science-based organization and its consumer knowledge as a patient-based organization, to inform the direction health care quality takes in the decades ahead.

ENSURE APPROPRIATE AND TIMELY ACCESS TO HEART DISEASE & STROKE CARE

Over the past decade, there has been a significant increase in both the number and percentage of Americans without health insurance, including individuals with cardiovascular disease and stroke. At the same time, a growing number of people with health insurance coverage are underinsured, meaning that their health insurance does not provide adequate financial protection when they are sick. (Gibbons, Jones et al. 2008)

The clinical literature overwhelmingly shows that uninsured and underinsured people, children as well as adults, suffer worse health and die sooner than those with insurance. Health insurance coverage in the United States is integral to individuals' personal well-being and health. Access to health services is directly impacted by access to meaningful health insurance. (Gibbons, Jones et al. 2008)

In the current healthcare system, individuals with chronic diseases such as heart diseases and stroke can face numerous challenges obtaining comprehensive, affordable healthcare coverage, often being denied coverage or charged higher premiums for a preexisting condition. For example, young people with congenital heart defects whose age renders them ineligible for their parents' health insurance are often unable to obtain coverage because of their risk profile. (Gibbons, Jones et al. 2008)

The majority of the uninsured are in working families. Those with low incomes make up a disproportionately large share of the uninsured. More than two-thirds of the uninsured have family incomes below 200% of the poverty

level (\$44,050 a year for a family of four). Low-income workers—those at greatest risk of being uninsured—are much less likely to be offered job-based coverage and are less able to afford their share of the premiums.

The Burden of Cardiovascular Diseases and Stroke in the United States

The burden of cardiovascular diseases and stroke can be particularly problematic for individuals without health insurance. Numerous studies have documented the detrimental health effects of being uninsured or underinsured on individuals with heart diseases and stroke. For example, people who lack health insurance experience a 24-to-56 percent higher risk of death from stroke than those who are insured. The impact of gaining healthcare coverage is greatest for those with a history of heart disease, stroke, high blood pressure or diabetes. (Gibbons, Jones et al. 2008)

Other studies show that in comparison to people with heart diseases and stroke who have insurance, the uninsured with heart diseases and stroke experience higher mortality rates, poorer blood pressure control, greater neurologic impairments and longer lengths of hospital stay after stroke, as well as a lower likelihood of taking appropriate medications. (Gibbons, Jones et al. 2008)

For the millions of individuals in the United States with cardiovascular diseases and stroke who do not have healthcare insurance, the challenges are tremendous. Gaining coverage can provide enormous health benefits for individuals with CVD.

Addressing Appropriate and Timely Access to Heart Disease and Stroke Care within the Context of Other Issues

Economic Recession

As the U.S. economy recovers from the recession, challenges exist. About two million people lost their employer-sponsored insurance in 2008—in large part from the recession. The unemployment rate climbed to 7.2 percent in December 2008—a 16-year high—with an estimated 11.1 million U.S. residents out of work. As a result, many working Americans lost access to affordable health benefits subsidized by their employers. (2009)

Over forty-six million nonelderly people were uninsured in 2008. More than one in six individuals under age 65 (17%) was uninsured in 2008, which puts their health and financial security at risk. (2009)

Increases in unemployment have already added to what has been a steady decline in employer-sponsored coverage since 2000. The percent of individuals under age 65 with employer-sponsored coverage is now 60 percent. (2009)

The recent recession made it difficult for some workers to find a job with insurance coverage or to afford the coverage that is offered. The percentage of firms offering coverage dropped from 69 percent in 2000 to 60 percent in 2009, which was in part due to rising premiums. In 2009, the annual total cost for family coverage purchased through an employer was \$13,375, more than double the cost in 2000. (2009)

The AHA's Policy Agenda to Address Access Issues

Health Insurance Reform

In 2008, AHA published its Principles for Healthcare Reform that include the following:

- All residents of the United States should have meaningful, affordable healthcare coverage;
- Preventive benefits should be an essential component of meaningful healthcare coverage, and incentives should be built into the healthcare system to promote appropriate preventive health strategies;
- All residents of the United States should receive affordable, high quality health care;
- Race, gender and geographic disparities in health care must be eliminated;
- Support of biomedical and health services research should be a national priority, and inflation-adjusted funding for the National Institutes of Health must be maintained and expanded; and
- The United States' healthcare workforce should continue to grow and diversify through a sustained and substantial national commitment to medical education and clinical training. (Gibbons, Jones et al. 2008)

The AHA's advocacy agenda is grounded in these principles. The American Heart Association advocates for affordable and appropriate health care coverage for all residents that also guarantees protection from extraordinary or catastrophic medical costs. The AHA will work to ensure that health coverage is universal,

continuous, high-quality, administratively simple, and affordable both to individuals and to society. We will assure that efforts to expand access include coverage for evidence-based prevention, diagnosis and treatment of heart disease and stroke. In collaboration with other organizations and government leaders, the AHA is working to promote health care solutions through a variety of measures.

Implementation of Health Reform in States – The Association will: Monitor opportunities within health reform implementation as part of the Patient Protection and Affordable Care Act, which includes a range of state requirements and options including state based health insurance exchanges, insurance regulations, and delivery system initiatives; ensure that state-based exchanges are established in alignment with AHA principles; promote opportunities for states to increase coverage for evidence-based CVD preventive services with no cost-sharing through provisions that provide a 1% Medicaid FMAP increase to states that cover these services, and to the extent possible support coverage of evidence-based non-CVD preventive services; ensure that adequate and science-based coverage and essential benefits under Medicaid, CHIP and exchanges are provided.

The AHA will continue to advocate for the following priorities:

Make certain that health coverage provides affordable access to individuals with pre-existing conditions.

Support health plan coverage that includes coverage for essential health care services including hospital and ambulatory care, prescription drugs, preventive services, emergency care, and rehabilitation.

Eliminate financial barriers to preventive services in public and private health insurance plans.

Make certain that health care plan networks include an adequate number and type of providers and provide consumers with complete and understandable information about health plan coverage, costs, and quality.

Ensure that the health care workforce includes providers adequate to meet the needs of individuals with or at risk of cardiovascular disease.

Chain of Survival/Emergency Medical Services

The delivery of high-quality health care is particularly important in emergency medical care, which covers a range of sites-of-care from public places to sophisticated surgical sites and a range of caregivers from lay responders to subspecialists.

Based on data from the Resuscitation Outcomes Consortium, it is estimated that 294,851 emergency medical services-treated out-of-hospital cardiac arrests occur annually in the United States. (Lloyd-Jones, Adams et al. 2009) About 60 percent of unexpected cardiac deaths are treated by emergency medical services. (Chugh, Jui et al. 2004) On average, 31.4 percent of out-of-hospital cardiac arrests receive bystander CPR. (Sayre, Berg et al. 2008) About 80 percent of out-of-hospital cardiac arrests occur in private or residential settings.

For an individual suffering a heart attack, cardiac arrest or stroke, time is the enemy. Those suffering sudden cardiac arrest (SCA) are at the highest risk, as brain death starts four-to-six minutes after the arrest. Cardiac arrest is reversible in most victims if it is treated within a few minutes with an electric shock to the heart through the process of defibrillation. A victim's chances of survival are reduced by 7 to 10 percent with every minute that passes without Cardiopulmonary resuscitation (CPR) and defibrillation. (Abella, Aufderheide et al. 2008)

To empower lay and medical responders in communities across the country to respond to cardiac arrest, the American Heart Association pioneered the -Chain of Survival. The Chain of Survival incorporates the vital links necessary for emergency response, including: Call 9-1-1; Early CPR; Early defibrillation; and Early advanced care from highly trained and equipped paramedics.

Public policy helps support each link in the chain through, for example:

- Community-enhanced 9-1-1 systems that aid in identifying the location of emergency victims and conveying pre-arrival instructions to rescuers;
- Investments in public and worksite CPR training and public outreach campaigns;
- Acquisition, training and accessible placement of automated external defibrillators (AEDs) to allow for prompt defibrillation by lay responders; and

Investment in infrastructure, training and equipment for community-based paramedics and other emergency responders.

Over the past decade, policymakers have supported the Chain of Survival through enactment of legislation at the state and federal level, including:

- The federal Cardiac Arrest Survival Act, which encouraged the placement of AEDs in federal buildings and helped clarify the use of AEDs under Good Samaritan laws;
- The federal Wireless Communications and Public Safety Act making 9-1-1 the universal emergency number and identifying strategies to improve 9-1-1 wireless service; and
- Legislation in all 50 states extending limited liability protection to lay users of AEDs rendering emergency care.

The Community Access to Emergency Defibrillation Act which authorized federal funding for communities to establish public access to defibrillation programs.

Today, the American Heart Association seeks to build on this foundation by supporting the following public policy goals:

Improve access to and use of automated external defibrillators (AEDs)

- The Association champions public policy initiatives that promote the purchasing and placement of AEDs for first responders and targeted responders in high-risk locations. For example, the Association supports enhanced investment in the federal Rural and Community Access to Emergency Devices (AED) Program. Although funding for the program has been significantly cut since 2002, the Association strongly supports restoring funding to support the placement of AEDs in rural communities.

Establish quality community-based AED programs

- The Association supports public policies that promote the expansion of community AED programs that are consistent with the American Heart Association's policy statements and guidelines. For example, the Association supports the federal Josh Miller HEARTS Act, which would create a federal grant program to fund the purchase of AEDs for elementary and secondary schools. The legislation requires adequate training for teachers and staff in the use of AEDs and encourages schools to create medical emergency response plans.

Adopt a strong stroke chain-of-survival

- The Association supports legislative and regulatory action to advance the development of a stroke chain-of-survival that includes rapid recognition of and reaction to stroke warnings signs, initiation of 9-1-1, prompt start to pre-hospital care, rapid emergency medical systems (EMS) transport, and timely hospital diagnosis and treatment.

Promote state 9-1-1 and emergency medical dispatch (EMD) quality assurance

- The Association supports public policy initiatives that focus on increasing the quality and appropriate use of 9-1-1 systems, including E-9-1-1. These initiatives should promote the use of nationally recognized emergency medical dispatch protocols and appropriate quality improvement programs among 9-1-1-dispatch agencies to assure that bystanders promptly receive effective CPR coaching. Further, they should support efforts to train dispatch personnel to provide pre-arrival medical instructions.

Promote CPR, AED, and First Aid Credentialing for Professionals

- The AHA supports public policy initiatives that require CPR, AED, and/or First Aid training for licensure/certification of those professionals that may need to respond to medical emergencies. Work to assure that AHA CPR, AED, and First Aid training are recognized by licensing agencies that regulate professions that are required to have CPR, AED and/or First Aid training for licensure/certification.

Support the Establishment of Quality Community CPR/AED Programs

- The AHA works to assure that all public policy related to Community CPR/AED programs are consistent with the American Heart Association's policy statements and guidelines. Support the implementation of quality Community CPR/AED programs that follow AHA guidelines.

Support the Establishment of Quality School Based CPR/AED Programs

- The AHA works to assure that public policy regarding the placement of AEDs in schools incorporates training and medical emergency response plans in schools. The AHA advocates that evidence-based CPR training, which incorporates psychomotor skills, be a high school graduation requirement.

Adopt strong EMS and EMS triage and transport protocols

- The Association supports public policy initiatives that promote a strong, well-trained, data- driven, quality EMS system that performs consistent with Association guidelines and continually improves its responsiveness and effectiveness.

Address barriers related to informed consent in emergency care research

Systems of Care for STEMI

Death and disability due to heart attacks could be reduced further by improving the coordination and communication among the professionals and institutions that play critical roles in delivering acute care to individuals experiencing heart attacks. A well-coordinated, timely response is critical for the heart attack victims who suffer a type of heart attack—known as a ST-elevation myocardial infarction or -STEMI—that is caused by the sudden blockage of an artery supplying blood to the heart.

Through evidence-based scientific guidelines, such as the ACC/AHA Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction, the American Heart Association recommends treating all eligible STEMI patients as quickly and optimally as possible. However, many STEMI patients do not receive a preferred treatment option because a coordinated system does not exist in many communities to ensure that these patients are transported to facilities with the capacity to perform timely lifesaving treatment(s).

Given the importance of addressing this barrier to health care services for heart attack patients, the American Heart Association developed the Mission: Lifeline initiative to help local communities create systems for activating the response necessary to ensure that individual patients receive acute treatment in a timely manner.

A new, coordinated statewide system is needed to focus on expediting and coordinating the identification, triage, emergency transport and acute treatment of individuals with heart attacks.

The AHA supports the following priorities in the context of STEMI care:

Establish STEMI systems of care across this country

- Through an integrated approach with the Mission: Lifeline initiative, promote efforts to create inclusive and coordinated statewide and regional systems of care to improve the treatment of STEMI patients by adhering to ACC/AHA guidelines and are consistent with Mission: Lifeline recommendations for criteria for STEMI systems of care.

Promote 12-lead electrocardiograms for every ambulance

- Support efforts that include encouraging EMS agencies to obtain or upgrade to effective 12-lead ECG field devices, including appropriations for training and equipment.

Promote related training for emergency medical services (EMS) providers related to STEMI care.

Support public funding to advance the clinical decision support program ACTION Registry – Get With the Guidelines, and advocate that this program serve as the state registry data platform.

Support Strong EMS Systems and EMS Triage and Transport Protocols

- Support public policy initiatives and other activities that promote a strong, well trained, data driven, quality EMS system that improves collaboration, responsiveness, and effectiveness. Assess, establish, encourage and promote the use of, and training on, ACC/AHA guideline based EMS triage and transport protocols for acute MI and stroke patients to ensure access to timely and appropriate evidence-based treatments.

Systems of Care for Stroke (See Appendix C for a summary of AHA stroke advocacy)

An estimated 795,000 U.S. residents have a new or recurrent stroke each year, and about 145,000 of these individuals die. An estimated 6.5 million Americans are stroke survivors. Stroke is a leading cause of serious, long-term disability. (Lloyd-Jones, Adams et al. 2009)

Building stroke systems throughout the United States is the critical next step in improving patient outcomes in the prevention, treatment, and rehabilitation of stroke. The current fragmented approach to stroke care in most regions of the United States provides inadequate linkages and coordination among the fundamental components of stroke care. (Schwamm, Pancioli et al. 2005) Providers and policymakers at the local, state, and national levels can make significant contributions to reducing the devastating effects of stroke by working to promote coordinated systems that improve patient care. (Schwamm, Pancioli et al. 2005)

A stroke system approach involves coordinating stroke care along the entire continuum, from primary prevention through rehabilitation. A systems approach is necessary to improve how stroke is treated so that patients have access to the most advanced treatment in centers that are best equipped to deal with their critical and time-sensitive needs.

The essential parts of a coordinated system of stroke care have been outlined by the ASA's Task Force on the Development of Stroke Systems in Recommendations for the Establishment of Stroke Systems of Care. The statement recommends that coordinated stroke systems promote patient access to the full range of services associated with prevention, treatment and rehabilitation, including these key components:

- Primordial and Primary Prevention;
- Notification and Response of Emergency Medical Services for Stroke;
- Acute Treatment for Stroke;
- Sub-Acute Stroke Care and Secondary Prevention for Stroke;
- Rehabilitation of Stroke Patients;
- Continuous Quality Improvement Initiatives. (Schwamm, Pancioli et al. 2005)

The AHA supports the following priorities in the context of stroke systems of care:

AHA will work in each of the 50 states to create inclusive and coordinated statewide systems of care to improve the treatment of the stroke patient.

- Working to ensure that the recognition, and the protection, of Primary Stroke Centers designation is based on Joint Commission certification or an equivalent process;
- Advocating for the utilization of current AHA/ASA guidelines for stroke care;
- Promoting within Emergency Medical Services Systems statewide standardization and implementation of stroke training, assessment, treatment, and transportation protocols;
- Supporting the utilization of telemedicine to help facilitate the links critical to establishing a meaningful system for stroke prevention, treatment, and rehabilitation;
- Supporting the removal of barriers for rehabilitation referral and rehabilitation treatment of stroke patients;
- Promoting the establishment and expansion of statewide registries which utilize Get with the Guidelines-Stroke as the state registry data platform;
- Ensuring transitional care across the continuum from Emergency Medical Services through Rehabilitation with emphasis on patient and family caregiver needs;
- The AHA will continue to work with CMS to ensure that Medicare reimbursement for stroke –drip and ship patients recognizes the additional expenses stroke centers incur when treating these patients.

At the Federal level, advocacy staff will continue to ensure that the needs of stroke patients are met as part of the implementation of meaningful, comprehensive healthcare reform.

Health reform presents an opportunity to address a number of the concerns that stroke patients and their families face. For example:

- Ensure that all individuals who experience a stroke have access to affordable, adequate health insurance;
- Improve the coverage of preventive services to help reduce the risk of stroke;
- Eliminate the 2-year waiting period for Medicare for stroke patients who are disabled and have no other insurance;
- Ensure that coverage for therapy services and other care needed by stroke patients is adequate for their full recovery.

- **Support Strengthening 9-1-1 Systems** The AHA supports public policy initiatives and other activities that promote increased quality and timely use of 9-1-1 systems. This includes the ability of current and future generations of telecommunications technology to supply E-9-1-1 capabilities to their customers.

Support Emergency Medical Dispatch (EMD)

- The AHA promotes the use of, and funding for, nationally recognized emergency medical dispatch protocols and appropriate quality improvement programs among 9-1-1-dispatch agencies to assure that bystanders promptly receive effective CPR coaching and support efforts to train dispatch personnel to provide pre-arrival medical instructions.

Support Strong EMS Systems and EMS Triage and Transport Protocols

- The AHA supports public policy initiatives and other activities that promote a strong, well trained, data driven, quality EMS system that improves collaboration, responsiveness, and effectiveness. Assess, establish, encourage and promote the use of, and training on, ACC/AHA guideline based EMS triage and transport protocols for acute MI and stroke patients to ensure access to timely and appropriate evidence-based treatments. (Acker 2007)

Development of Coordinated Stroke Systems of Care through Telemedicine

- The AHA supports the utilization of telemedicine, which is consistent with AHA science and policy statements, to help facilitate the links critical to establishing a meaningful system for stroke prevention, treatment, and rehabilitation. (Schwamm, Audebert et al. 2009; Schwamm, Holloway et al. 2009)

New models and codes for reimbursement of telestroke services should be developed to reflect the increased upfront costs to providers and reduced long-term healthcare costs to insurers.

- Increased reimbursement under Medicare for tPA delivery in the United States under stroke thrombolysis DRGs (MS-DRG 61, 62, and 63) should be available to hospitals that supervise the initiation of intravenous tPA via telestroke consultation and then accept these patients in transfer for admission to the hub hospital. This rate should reflect the full reimbursement to the hub hospital for MS-DRG 61, 62, and 63 minus the drug costs that are already being paid to the spoke facility via the outpatient prospective payment system;
- A similar cost-sharing model should be considered for hospitals that receive patients after tPA delivery but that did not participate in the decision to deliver tPA via telestroke;
- Medicaid and private payers should adopt similar payment policies;
- There should be increased professional reimbursement for telestroke services that reflects the increased burden this coverage places on acute stroke providers;
- Reimbursement for telestroke services by Medicare, Medicaid, and other insurers should occur regardless of whether the originating site is a spoke hospital in a rural or metropolitan census tract, because the shortage of acute stroke–capable providers is a growing problem that affects patients cared for at both rural and metropolitan hospitals;
- On-call stipends or other incentives should be provided to encourage broad participation by acute stroke consultants and increase the available pool of physicians who can provide this much-needed telestroke expertise.

Rehabilitation

- The AHA supports the removal of barriers for rehabilitation referral and rehabilitation treatment of stroke patients (see below).

Systems of Care for Out-of-Hospital Cardiac Arrest

A recent AHA Scientific Statement reiterates the importance of developing regional systems of care for out-of-hospital cardiac arrest to increase survival rates. Recommendations were: (Nichol, Aufderheide et al. 2010)

- A community-wide plan to optimize treatment sequentially from successful out-of-hospital resuscitation to hospital discharge should be implemented;
- A priori agreements between EMS and hospitals should be established with protocol-driven decisions to match patient needs with the capability of the transport-destination hospital to meet those needs. The content and timeliness of communication from EMS to hospitals should be addressed to proactively mobilize healthcare personnel before arrival and reduce time delays to treatment;
- Regional systems may involve a town, a city, a county, a state, or another region of the country. Systems should include academic or community receiving hospitals with multidisciplinary teams, including cardiology, critical care, and neurology. The volume of patients who have restoration of circulation after cardiac arrest is not solely tied to institutions but to practitioners who practice at multiple institutions;
- Referral hospitals will continue to play a vital role in optimizing care for patients with restoration of circulation after OOHCA. Their immediate efforts, before transfer to the receiving hospital, in initiating therapeutic hypothermia early in conjunction with EMS will be important in the final outcomes of many patients. Referral hospitals should be provided with the necessary funds for equipment and education and be required to follow specific patient care and triage protocols, and they should report their experience, as has been done in selected inclusive regional trauma systems;
- As with trauma centers, burn centers, STEMI centers, and stroke centers, national criteria should be developed to enable the categorization, verification, and designation of centers for the treatment of patients with restoration of circulation after OOHCA. External credentialing should be required as opposed to self-designation to support the development and sustainability of adequate patient volumes and high-quality care. The number of level 1 cardiac resuscitation centers in a given region should be limited to maintain provider skill levels and to justify the initial costs and institutional commitment required to care for these specialized patients;
- Assessments of provider or hospital performance of acute coronary angiography should separate procedures performed in patients resuscitated from cardiac arrest from those performed in other patients

to reduce potential disincentives to the performance of an intervention in these patients with high morbidity and mortality;

- Evidence-based best practices and model EMS protocols should also be developed to guide states and local EMS systems in developing inclusive regionalized approaches to post-resuscitation care.

Congenital Heart Disease

Often viewed as a problem of adults, cardiovascular disease also exacts a terrible toll on the young. Congenital cardiovascular defects, also known as congenital heart defects (CHD), are the No. 1 birth defect in the U.S. (2006) and the No. 1 killer of infants with birth defects. Nine out of 1,000 babies—an estimated 36,000 infants—are born with CHD each year. (CDC 2008) Tragically, more than 1,600 of them do not live to celebrate their first birthday. (2006) Beyond the terrible death toll, physical and mental suffering, and lost potential and productivity that CHD causes, it also comes with a steep price tag. In 2004, hospital costs for all individuals with CHD totaled \$2.6 billion. (Russo 2007) But there is still real reason for hope. Due to research, most survive to adulthood, including many who formerly would have died. (Cole 2007) However, the survivors—particularly those with more complex forms of CHD—are more likely to develop additional heart problems later in life. Young adults with CHD also face enormous barriers to effective health care, particularly when they are no longer covered by their parents' health plans. Few health and life insurance companies are willing to underwrite them, or the cost is prohibitive. And the prevalence of congenital cardiovascular defects has increased strikingly in both adults and children due to increased survival. A recent study shows that severe congenital heart disease rose by 85% in adults and 22% in children due to increase survival. (Marelli, Mackie et al. 2007) As of 2002, it was estimated that 650,000 to 1.3 million Americans had congenital heart disease and more recent studies show these numbers could be increasing. (Hoffman, Kaplan et al. 2004)

The AHA is committed to advancing public policies that will allow children and adults with heart defects to live longer and fuller lives. These policies include:

More public resources devoted to researching the causes and treatment of CHD throughout the lifespan, along with specialized programs of care needed for children and adults with CHD.

Require birthing facilities to perform a pulse oximetry screening on every newborn in its care prior to discharge from the birthing facility.

Support for CDC's Birth Defects Centers to advance our knowledge of the preventable causes of CHD.

Support for activities across the lifespan including research in transition of care; increasing awareness among parents, families, and healthcare providers about CHD; and improving understanding of healthcare utilization, costs, and needs for the growing adult population.

Improving access to preconception and prenatal care for women of reproductive age to reduce modifiable risk factors for CHD.

Eliminating health insurance penalties for pre-existing conditions in children and adults.

Peripheral Artery Disease

The AHA will take a leading role in advocating for public and professional awareness of peripheral artery disease (PAD) and critical limb ischemia.

The AHA supports reimbursement for assessment of ankle-brachial index.

The AHA advocates for adequate reimbursement for exercise rehabilitation, diet and weight management therapy for patients diagnosed with PAD.

Surveillance Programs

The success of efforts to prevent and manage heart disease and stroke is dependent on the availability of surveillance data at the national, state, and local levels to assist federal agencies, state and local health departments, and their partners in assessing prevention and treatment priorities and guiding program planning, implementation, and evaluation. (Goff, Brass et al. 2007)

The AHA supports the following priorities in the context of surveillance programs:

A National Heart Disease and Stroke surveillance unit should be established to produce annual reports on key indicators of progress in the prevention and management of heart disease and stroke.

States, territories and tribal organizations should develop surveillance capacity to support program planning, implementation, and evaluation, including the ability to conduct standardized surveys that include direct assessments of residents to enable collection of information regarding prevention, awareness, detection, treatment and control of obesity, hypertension, dyslipidemia, and diabetes.

Establish surveillance capacity for monitoring all metrics for AHA's 2020 Impact Goal and the closely related Healthy People 2020 Objectives.

Pre-Hospital Data Collection

Strengthen and coordinate pre-hospital data collection, including supporting efforts to implement/expand EMS participation in the National EMS Information System. Support policies that coordinate the linkage of pre-hospital data to hospital level data. Support policies which improve data quality and increase provider participation.

Electronic Medical Records

- Monitor the role that the development and implementation of electronic medical records, and related health information technology strategies, have in heart disease and stroke standardized data collection.

Stroke Registries

- Promote the establishment and expansion of statewide registries that compile stroke incidence and care information and statistics that align with the stroke consensus metrics developed and approved by the AHA/ASA, CDC and Joint Commission. Through legislation, regulations and/or other appropriate means, advocate for Get with the Guidelines – Stroke as the state registry data platform. Support public funding to advance clinical decision support programs, such as Get With the Guidelines.

Heart Disease Registries

- Promote the establishment and expansion of statewide registries that compile information and statistics on heart disease incidence and care. Support public funding to advance clinical decision support programs, which align with AHA evidence-based guidelines, data elements and definitions, and advocate that these programs serve as the state registry data platform.

Reportable Conditions

- Support designation of acute cardiovascular events as reportable conditions, e.g., out-of-hospital cardiac arrest, acute coronary events, and strokes.

Rehabilitation

The American Heart Association and its American Stroke Association division prioritize advocacy issues around rehabilitation for heart and stroke patients and support more research to define optimal treatment approaches and settings for rehabilitation and recovery. The AHA supports the following priorities in the context of rehabilitation:

Support more research to define optimal treatment approaches and settings for rehabilitation and recovery

Adequate coverage and reimbursement for cardiac rehabilitation services

Repeal therapy caps

- The AHA/ASA are working to ensure that Medicare beneficiaries who suffer a stroke will continue to have access to needed physical, occupational, and speech therapy services. About 4.4 million Medicare beneficiaries are living with the consequences of stroke, and Medicare beneficiaries suffering a stroke often need extensive therapy. (2009) The Medicare therapy caps were originally adopted by Congress in the Balanced Budget Act of 1997. Since 1999, Congress has acted to prevent implementation of the caps by passing several moratoria and authorizing an exceptions process. The AHA/ASA support the repeal of the Medicare therapy caps and have endorsed legislation, the Medicare Access to Rehabilitation Services Act (S. 46/ H.R. 43), that would permanently repeal the caps. However, because budget constraints make permanent repeal of the caps by Congress unlikely, the American Heart

Association has also urged Congress to continue to extend the exceptions process to ensure that Medicare beneficiaries who have a stroke have access to necessary therapy services.

The AHA will also work at the state level to remove barriers that currently exist limiting the ability of patients to receive appropriate stroke and cardiac rehabilitative services.

Reimbursement

While exceptions exist, AHA rarely advocates for reimbursement changes that would directly impact providers unless sufficient evidence exists that the current policy provides barriers to care for patients. Reimbursement advocacy is best left to organizations that represent only physicians or other individual stakeholder groups. Regardless, the AHA will—and often does—comment on regulations and rules that either directly or indirectly impact reimbursement levels. The purpose of AHA's comments is often to share the latest science with a regulatory agency. (Bufalino, Peterson et al. 2006)

The AHA supports the following priorities in the context of reimbursement:

Monitor Pay-for-quality and Non-financial Incentives

- The AHA will identify and support and encourage continued development of policies that use sound scientific methods of performance measurement and analysis to align financial and non-financial incentives, including public reporting, in support of the provision of high quality health care—care that is safe, effective, patient-centered, timely, efficient and equitable. The AHA will monitor such policies for their use of both clinical and administrative data. In addition, the AHA will educate policy-makers to understand the strengths and weaknesses of each type of evidence.

Telemedicine

The use of telemedicine in the treatment of stroke—commonly referred to as -telestroke—has shown great promise in improving patient access to recommended stroke treatments in rural and other -neurologically underserved areas. The American Stroke Association is working to address barriers to stroke telemedicine, such as the need for funding to implement telestroke networks and the lack of Medicare reimbursement for telemedicine consultations when the patient is located in an urban or suburban area. (Schwamm, Audebert et al. 2009)

The AHA supports the following priorities in the context of telemedicine:

Support and advance the Rural Tech Act, the Medicare Telehealth Enhancement Act and other federal legislation that advances telemedicine.

Advocate that information technology funds appropriated in the American Recovery and Reinvestment Act and other federal legislation be used for telehealth purposes.

Monitor implementation of the telehealth provision (in the CMS innovation center section) and remote monitoring provisions in health reform legislation.

The AHA promotes the following principles around telestroke: (Schwamm, Audebert et al. 2009)

Whenever local or on-site acute stroke expertise or resources are insufficient to provide around the clock coverage for a healthcare facility, telestroke systems should be deployed to supplement resources at participating sites. This should be done within the context of a stroke system of care framework wherever possible.

Organizations providing or requesting telestroke services should operate under rules and principles governed by contractual agreements between the parties including:

- Assignment of the costs of developing and maintaining the telemedicine network;
- Compliance with relevant federal, state, and local statute boundaries and any existing noncompeting relationships;
- Assessment of medicolegal risk and provision of adequate malpractice coverage;
- Compliance with relevant regulations for the sharing of protected health information;
- Administrative and licensing/credentialing requirements for all providers;
- Methods and nature of reimbursement for professional services at fair market value or under safe harbor from government statutes related to fraud and abuse;
- Explicit delineation of roles and responsibilities of all providers during and after stroke consultation.

Medical advice should be provided during telestroke consultation in a manner similar to that which occurs during on-site consultation, and documentation of the recommendations should be made available to the originating site within a reasonable time after completion of the consultation.

Technology providers should adhere to widely accepted industry standards.

Technology solutions should include easy to use standard features to ensure an adequate visualization of the patient and surrounding environment, examination of the patient and opportunity to interact with others at the bedside including providers and caregivers.

New models and codes for reimbursement of telestroke services should be developed to reflect the increased upfront costs to providers and reduced long-term healthcare costs to insurers.

A mechanism for a uniform national U.S. licensure process limited to telemedicine practice should be adopted by State Medical Boards, and a uniform streamlined credentialing and privileging process for telestroke providers should be adopted by hospitals.

Telestroke networks should be deployed wherever a lack of readily available stroke expertise prevents patients in a given community from accessing a primary stroke center (or center of equivalent capability) within a reasonable distance or travel time to permit access to specially trained stroke care providers.

Institutions seeking to develop hub and spoke telestroke networks should attempt to include key stakeholders from the beginning of the process to ensure successful adoption and sustainability.

Workforce

Some experts, such as the Council on Graduate Medical Education, are predicting a physician shortage in the coming years. (2005) Others argue we should reduce disparities in the distribution of the physician workforce, including reallocating medical education funding to favor primary care, geriatric and palliative care, which are areas that have the potential to improve care coordination and chronic disease management. (Goodman and Fisher 2008)

There is also a nursing shortage that is likely to become acute by the aging of the baby boomers. Inadequate levels of nursing staff could jeopardize patient safety, reduce care coordination and weaken efforts to improve chronic disease management. (2009) As the health care system responds to these changing workforce dynamics, new models of care delivery are evolving, including greater use of non-physician providers, allied health and public health professionals. (Gibbons, Jones et al. 2008)

The AHA believes that the United States healthcare workforce should grow (or adjust) as appropriate, and diversify through a sustained and substantial national commitment to medical education and clinical training. (Gibbons, Jones et al. 2008)

The AHA supports the following priorities in the context of workforce:

Provide sufficient public health and medical education funding and clinical training resources to improve chronic disease management, care coordination and patient-centered care support and promote the

development of new models of care delivery, including those that emphasize team-based approaches using allied health professionals. (Gibbons, Jones et al. 2008)

Access to services

- The AHA will monitor and pursue opportunities at the state level to address workforce capacity and access to services.

Genetics and Personalized Medicine

The use of genetics is being integrated into health care more frequently. Genetic testing is now being used to 'personalize' patient care according to each patient's genetic profile, improving the treatment of cardiovascular and other diseases. As scientists develop a greater understanding of the genetics of chronic diseases like heart disease and stroke, their discoveries will lead to further advances in health care.

To fulfill the promise of personalized health care, federal government support, funding and commitment is needed. The Federal government should invest in research to learn how genetics affect disease and treatment, and how to translate those findings into enhanced patient care.

The AHA supports the following priorities in the context of genetics and personalized medicine:

Increase funding for research on the genetics of heart disease and the translation of new discoveries into preventive measures and treatments.

Ensure disclosure of test validity and require appropriate regulatory oversight for marketed tests to assure physicians and the public of test quality.

Protect individuals undergoing genetic tests from discrimination by all forms of insurance.

Ensure that personalized healthcare services are accessible to all.

Educate and train the medical workforce to prepare for the expanded integration of genetics into healthcare practice.

Integrate personalized healthcare with health IT to deepen our understanding of the relationship between genetics, disease, treatments and outcomes.

Ensure that intellectual property practices foster innovation and the development of new genetic tools.

Educate the public about personalized healthcare and encourage them to collect their family medical history.

PROTECT THE NON-PROFIT ENVIRONMENT

As the nation's largest nonprofit organization devoted to the fight against heart disease, stroke and other cardiovascular illnesses, the American Heart Association is sustained and supported through the commitment of our volunteers and generous financial support of our donors and supporters. The legislative, regulatory and administrative action of government can have a profound impact on the ability of the AHA to effectively fundraise, organize and pursue strategies to achieve our Mission of building healthier lives, free of cardiovascular diseases and stroke. For this reason, the Association reserves a portion of its advocacy capacity to monitor and as appropriate, pursue public policy objectives that encourages and supports a responsive and vibrant non-profit sector and the work of the American Heart Association.

The AHA was founded in 1924 by six cardiologists, who recognized the need to widely share their heart disease education and research. In 1948, the Association transformed from a scientific society into a voluntary health agency. In June 1997, the AHA became a single charitable 501(c)(3) corporation registered in New York State. The Association maintains operations in all 50 states and U.S. territories including health impact, development and fundraising initiatives. Given this, the AHA has organizational interests in federal and state public policy that

has implications on the operations of non-profit. Advocating for legislative and regulatory actions consistent with its Mission is both a legitimate and appropriate activity for charitable organizations. The AHA does not operate an affiliated 501(c)(4) and therefore does not engage in political campaigns or attempt to influence the election process.

Protect Non-Profit Sector Interests

Nonprofit organizations are a critical component of our nation's economy and provide an invaluable public service. The AHA believes that improving the capacity of nonprofits yields significant dividends for government and society. To promote, protect and preserve the important role and contributions that voluntary health organizations, the AHA works in coalition with other non-profits (e.g., Independent Sector) to monitor and ensure that legislative, regulatory and government agency support the continued vitality of the sector.

The AHA firmly believes that the nonprofit community has a vested interest and responsibility to police itself and embrace standards that hold the sector accountable for independent governance, rigorous accountability and full transparency. We also recognize the important oversight role of government. The AHA supports appropriate reporting requirements that do not place an undue burden on charitable organizations and are focused on preserving the public's interest and confidence in the nonprofit sector. The AHA support aggressive enforcement actions against certain -look-alike organizations seeking to mislead or confuse potential donors for supporting the charity of their choice.

As a charitable organization dependent on broad based community level financial support, the AHA is very concerned about fees assessed on charitable activities and potential restrictions placed on fundraising activities in schools.

Promote Tax Policy Conducive to Charitable Organizations

Federal and state tax policy plays an important role in encouraging and supporting individuals who want to support charitable organizations through tax deductions. Similarly, favorable state and local income, property and other tax policy is essential to enable charitable organizations to maximize their ability to preserve and direct donor dollars to Mission related activities. Nonprofits have also been hit particularly hard during the recent economic downturn, making a favorable tax environment for charities even more crucial. The Association supports responsible policies that encourage individual and corporate charitable giving, Foundation support and preservation of operational benefits associated with tax-exempt status. Estate tax should be maintained at necessary levels that do not discourage or otherwise have a detrimental impact on the ability of families to leave gifts to charities of their choice through planned giving. The AHA opposes efforts to expand the applicability of the unrelated business income tax to activities that are substantially related to a nonprofit's mission.

Encouraging Volunteerism

Public policy can play an important role in providing strong incentives for Americans to give their time in service to charitable organizations, including the American Heart Association. The AHA generally supports efforts to encourage people of all ages to volunteer, including the Serve America Act and maintaining an appropriate deduction for mileage expenses incurred during volunteer service.

Preserve Public Funding for Voluntary Health Organizations

The limited exceptions, the American Heart Association do not solicit or accept government funding to support its Mission-related activities. However, the AHA believes that there is an essential role for the government to provide adequate public support for our voluntary health partners, ensure delivery of essential public health services, and address disparities and the needs of our nation's most vulnerable populations.

Safeguard the Ability of Charitable Organizations to Engage in Advocacy

While 501(c)(3)s are prohibited from engaging in partisan political activities, they are allowed to engage in non-partisan advocacy and lobbying activities. Congress has recognized the importance of advocacy and lobbying by nonprofit organizations and provided very specific guidance on the types, nature and limitations of such nonpartisan lobbying activities. The AHA maintains a very robust advocacy program within these guidelines and similar rules and regulations at the state and local level. While the AHA supports appropriate expenditure limits for nonprofits and restrictions related to engaging in partisan activity, we vigorously preserve the ability of nonprofits to inform, influence and advocate for public policy consistent with the Association's Mission, interest and priorities. This includes reasonable lobbying registration fees and reporting requirements.

**American Heart Association
Policy Strategies to Achieve Ideal Cardiovascular Health**

Measure of Cardiovascular Health	Advocacy/Policy Solutions
<p style="text-align: center;">Smoking Status</p> <p style="text-align: center;"><i>Ideal for cardiovascular health:</i></p> <p>Adults: Never smoked or quit more than a year ago Children: Never tried or never smoked a whole cigarette</p> <p style="text-align: center;">Go to http://www.heart.org/tobaccocontrol for additional policy resources</p>	<ul style="list-style-type: none"> • Comprehensive clean indoor air laws • Excise taxes on tobacco products • Increase/sustain funding for state smoking cessation/prevention programs • Comprehensive implementation of FDA regulation of tobacco • Implement clinical guidance and monitor health claims around smokeless tobacco and other -harm reduction products. • Comprehensive smoking cessation benefits in Medicaid, Medicare and other health plans. • Eliminate tobacco sales in pharmacies and other health-related institutions.
<p style="text-align: center;">Physical Activity</p> <p style="text-align: center;"><i>Ideal for cardiovascular health:</i></p> <p>Adults: At least 150 minutes of moderate or 75 minutes of vigorous physical activity each week Children: > 60 minutes moderate-vigorous physical activity/day</p> <p style="text-align: center;">Go to www.fitkidsact.org, AHA's Worksite Wellness Page and http://www.heart.org/obesitypolicy for additional policy resources</p>	<ul style="list-style-type: none"> • Address the built environment and support efforts to design workplaces, communities, and schools around active living; integrate physical activity opportunities throughout the day. • Fund and develop walking/biking trails that connect key aspects of the community, increase Safe Routes to School, implement zoning/building ordinances that encourage walking/stair use, wider streets to allow for biking and walking, pedestrian-friendly streets and roadways with appropriate cross-walks, sidewalks, traffic lights, etc., and slower speed limits in walking/biking areas. • Implement shared use of school facilities within the community and support the construction of school fitness facilities. • Increase sports, recreational opportunities, parks, and green spaces in the community. • Increase the quantity and improve the quality of physical education in schools. Also, support 60 minutes per day of supervised, moderate-vigorous physical activity integrated throughout the school day. • Help implement the national physical activity plan.
<p style="text-align: center;">Body Mass Index (BMI)</p> <p style="text-align: center;"><i>Ideal for cardiovascular health:</i></p> <p>Adults: BMI between 18.5 and 25 kg/m Children: BMI between the 15th and 85th percentile</p> <p style="text-align: center;">Go to http://www.heart.org/obesitypolicy for additional policy resources</p>	<ul style="list-style-type: none"> • Adequate prevention, diagnosis, treatment of overweight and obesity in the healthcare environment. • Robust surveillance and monitoring • Comprehensive worksite wellness programs • Implement and monitor strong local wellness policies in all schools. • Adequate funding and implementation of coordinated school health programs • Comprehensive obesity prevention strategies in early childhood and day care programs

Healthy Diet

Ideal for cardiovascular health:

Adults and children should achieve 4 of the 5 following key components of a healthy diet:

- Fruits and vegetables: > 4.5 cups/day
- Fish: > two 3.5 oz. servings/week (preferably oily fish)
- Fiber-rich whole grains (> 1.1 g of fiber per 10 g of carbohydrates): three 1-oz-equivalent servings per day
- Sodium: <1500 mg/day
- Sugar-sweetened beverages: <450 kcal (36 oz.) per week

Go to <http://www.heart.org/obesitypolicy> for more specific policy resources

- Work to eliminate food deserts and improve access and affordability of healthy foods
- Strengthen nutrition standards in schools for meals and competitive foods and in all government nutrition assistance or feeding programs
- Improve food labeling
- Menu labeling in restaurants
- Continue to monitor the removal of industrially-produced trans fats from the food supply and assure the use of healthy replacement oils.
- Address food marketing and advertising to children
- Nutrition education/promotion in schools
- Limit added sugar and sodium in the food supply

Total Cholesterol

Ideal for cardiovascular health:

Adults: Total cholesterol less than 200 mg/dL
Children: <170 mg/Dl

- Assure adequate health care coverage for prevention and treatment of dyslipidemia
- Increase funding for programs that eliminate health disparities

Blood Pressure

Ideal for cardiovascular health:

Adults: Below 120/80 mm
Children: <90th percentile

- Reduce sodium in the food supply
- Increase funding for state heart disease and stroke prevention programs
- Ensure the availability of essential cardiovascular disease preventive benefits in private insurance and public health programs.

Fasting Plasma Glucose

Ideal for cardiovascular health:

Children and Adults: Fasting blood glucose less than 100 mg/Dl

- Assure adequate health care coverage for early treatment and prevention of diabetes
-

**The Impact of Advocacy on the American Heart Association’s 2020 Impact Goals for Prevention:
An Inventory Grid**

Policy	Potential Health Impact	Impact on Disparities*	Health Factors	Current Reach Federal/State/Local
Tobacco				
Clean Indoor Air Laws	Studies from around the world have shown the correlation between smoke free air laws and decreased rates of myocardial infarction. ⁱ Estimated <i>annual excess deaths</i> for the total U.S. population due to SHS exposure is 46,000 (a range of 22,700 to 69,600) from cardiac-related illnesses. It is also estimated that between 24,300 and 71,900 <i>low birth weight or preterm deliveries</i> are due to SHS exposure. ⁱⁱ		Tobacco	State, Local Across the United States, 21,884 municipalities are covered by a 100% smoke free provision in non-hospitality workplaces, and/or restaurants, and/or bars, by either a state, commonwealth, territorial, or local law, representing 79.7% of the US population. ⁱⁱⁱ
Coverage of tobacco cessation programs in health care plans	Upon implementation of a comprehensive cessation benefit, in just over two years, 26% of MassHealth smokers quit smoking and there was a decline in the utilization of other costly healthcare services (38% decrease in hospitalizations for heart attacks; 17% drop in emergency room and clinic visits due to asthma; and a 17% drop in claims for adverse maternal birth complications, including pre-term labor) ^{iv}	Despite our progress, 23.1% of men and 18.3% of women in the U.S. still smoke and our efforts have stalled in the last five years, especially for people living below the poverty line and for those with low educational attainment. ³	Tobacco	Federal, State
Restrict tobacco marketing & advertising	Reduction of tobacco sales, marketing and tobacco use by youth ^{v,vi}		Tobacco	Federal, State, Local Cigarette marketing expenditures declined from \$12.5 billion in 2006 to \$9.9 billion in 2008; smokeless tobacco marketing increased from \$354.1 million in 2006 to \$547.9 million in 2008. ^{vii}
Tobacco excise taxes	For every 10 percent increase in the real price of cigarettes there is a reduction in overall cigarette consumption by ~3-	Low-income smokers are much more likely to quit because of state tobacco tax increases	Tobacco	Federal, State There is some level of tobacco excise tax in every state.

	5%; lowers the number of young-adult smokers by 3.5%, and cuts the number of kids who smoke by 6-7%. ^{viii} Other estimates are that a 40% tax-induced cigarette price increase would reduce smoking prevalence to 15.2% in 2025 with large gains in cumulative life years (7 million) and quality adjusted life years (13 million) for a total cost-savings of \$682 billion. ^{ix}	than higher-income smokers ^x		Overall, all states' average is \$1.46/pack. Federal excise tax is \$1.01/pack for cigarettes and .40/cigar ^{xi}
Physical Activity				
Physical Education in Schools	Increased physical activity; If lifetime physical activity skills are taught at both school and home, children will have the optimal foundation for healthy living. ^{xii}		Physical activity	Federal, State, Local
Built Environment	Communities with safe sidewalks, green spaces, parks, public transportation, and ready access to fruits and vegetables lower the risk for developing diabetes and other chronic disease as compared with those communities that do not have these resources. ^{xiii}		Physical activity, Diet, Diabetes, and Weight	Federal/State/Local
Active Design	People who have parks or recreational facilities nearby and live in communities with well-connected streets exercise much more than those who do not have easy access. ^{xiv, xv}	Lower-income communities, especially in predominantly Latino or African-American neighborhoods, often have fewer resources to support active lifestyles and places to play and exercise. ^{xvi} Programs targeted to low-income, racially and ethnically diverse populations can increase active commuting and are associated with higher overall levels of moderate to vigorous physical activity throughout the day. ^{xvii}	Physical activity, Diabetes, and Weight	Federal, State, Local (Community/Workplaces/Schools)
Safe Routes to Schools	Children who walk and bike to school are more physically active, have lower obesity rates, and are more likely to meet physical activity guidelines ^{xviii, xix, xx}		Physical activity/Weight	Federal/State/Local Between 2005 and 2011, approximately \$950 million were allocated to state DOT's; all 50 States and the District of

				Columbia including 10,000+ schools are implementing child pedestrian and bike programs. Demand for such programs far exceeds the supply of funding available.
Complete Streets	Increased physical activity		Physical activity	Federal, State, Local In total, 314 jurisdictions have adopted policies or have made written commitment to do so, including 25 states, the Commonwealth of Puerto Rico, and the District of Columbia. ^{xxi}
Shared Use of Facilities	Physical Activity and Access to Healthier Foods		Physical activity and Diet	State, Local
Diet/Nutrition				
Addressing Food Deserts	Currently being studied	Food deserts are most often in economically distressed communities in urban and rural areas which are typically served by fast food restaurants and convenience stores that offer little or no fresh produce	Diet/Weight	Federal, State, Local Public and private funding across several states; some federal funding. Pennsylvania Fresh Food Financing Initiative brought 68 grocery stores to underserved communities.
Menu Labeling	Some evidence of increased consumer knowledge about portion size and caloric intake; industry innovation leading to healthier food offerings. ^{xxii,xxiii}		Diet	Federal, State, Local With new federal mandate, there will be reach in all 50 states and US Territories in chains with <u>>20</u> restaurants; also on vending machines
Reducing sugar-sweetened beverage consumption	Reduced calorie and added sugar consumption in the US population; reduction in obesity; if any revenues raised are reinvested in public health programs, benefits could be more pronounced. ^{xxiv}		Diet/Obesity	Federal, State, Local
Reducing Sodium in the Food Supply	It is estimated that if the U.S. population moved to an average intake of 1500 mg of sodium/day there would be a 25.6 percent overall decrease in	Hypertension rates disproportionately affect some racial/ethnic populations.	Blood Pressure/Diet	Federal, State, Local

	high blood pressure. ^{xxv} A national effort that reduces sodium intake by 1200 mg/d could result in 60,000 to 120,000 fewer CHD events, 32,000 to 66,000 fewer strokes, 54,000 to 99,000 fewer heart attacks, and 44,000 to 92,000 fewer deaths, and save 194,000 to 392,000 quality-adjusted life-years and \$10 to \$24 billion in healthcare costs annually. ^{xxvi}			
Reducing <i>trans</i> fat in the food supply	Improved cardiovascular health; increase in HDL and decrease in LDL cholesterol ^{xxvii}		Cholesterol/Diet	Federal, State, Local Over 50% of <i>trans</i> fats have been removed from the food supply
Food Procurement Standards	Nutrition; increasing access to healthy foods		Diet	Federal, State, Local Federal procurement standards will impact 1 million civilian employees of the federal government; many states and localities are currently considering procurement standards.
Children & Food Marketing Principles	A ban on television fast food advertising might reduce the number of overweight children by as much as 18 percent. ^{xxviii,xxix}	Food advertising particularly influences and harms at-risk children. Children in lower-income families, where obesity rates are higher, watch more television than those in higher socioeconomic classes, ^{xxx} increasing their exposure to advertising and reducing their physical activity.	Diet	Federal, State
Food Pricing	Access to healthier foods; deterrence to purchase unhealthy foods		Diet	Federal, State
School Nutrition Standards	Healthy diet; improved access to healthy foods		Diet	Federal, State, Local Recently finalized and updated USDA school meal standards will reach almost every school across the country. Competitive food standards coming in 2012.

Increasing access to healthy, affordable foods in communities	Lower risk of developing chronic disease; increased fruit, vegetable, whole grain, seafood, and low fat/no fat dairy consumption.		Diet	Federal, State, Local
Improved food labeling	Increased consumer education around healthy food choices		Diet	Federal
Obesity				
Obesity screening, diagnosis, and treatment in the healthcare environment	Early diagnosis, prevention and treatment of obesity		Weight	Federal, State, Local
BMI surveillance in schools or during clinical visits	Early diagnosis and treatment of obesity		Weight	Federal, State, Local
Overarching Prevention Efforts				
Healthcare Access	Blood pressure, cholesterol, diabetes management, diet, tobacco use screening and cessation treatment, obesity screening, diagnosis, and treatment	Risk factors are disproportionately found in certain racial/ethnic groups as well as low SES groups and those less educated	Multiple	Federal, State, Local
Comprehensive Workplace Wellness	Tobacco cessation, increased physical activity, improved access to healthy foods; weight and disease management		Multiple	Federal, State, Local
National Physical Activity Plan Implementation	Increased physical activity in the U.S. population through environment, systems, and policy change	Special focus on disparate populations	Physical activity	Federal, State, Local
Nutrition and Physical Activity standards in the preschool environment	Unfortunately, even obese preschoolers are showing some of the biomarkers related to cardiovascular risk. ^{xxxii} Early intervention to reduce obesity and related cardiovascular disease risk factors is critical; assure that healthy foods are served in age-appropriate portion sizes, screen time is reduced or eliminated, and children receive the recommended 60 minutes of physical activity/day. Provide better support for caregivers to promote healthy behaviors. ^{xxxiii}	Many children from low-income backgrounds consume 50% to 100% of their Recommended Dietary Allowances in a child care setting. ³⁰	Diet/Physical activity/Weight/Blood Pressure/Cholesterol	Federal, State, and Local The 2005 National Household Education Survey reports that 74% of all US children aged 3 to 6 years not yet in kindergarten were in some form of non-parental care, and 57% were in a center-based child care program. ^{xxxiii} In the federal Head Start program there are more than 1 million children and 200,000 staff members across the United States
Wellness Policies in Schools	Nutrition standards, nutrition promotion, physical activity, food marketing		Diet/Physical Activity/Weight	In all school districts across the country

*AHA addresses health inequities as a priority throughout its advocacy work. Only a special impact is noted in the table.

Heart Disease and Stroke. You're the Cure.



The American Heart Association Addressing Health Disparities in **Advocacy**

The American Heart Association pursues a comprehensive advocacy agenda to address a range of issues in the areas of heart disease and stroke research, cardiovascular health (nutrition, physical activity, obesity treatment and prevention, tobacco cessation and prevention, and air pollution), the quality and value of heart disease and stroke care, and appropriate and timely access to care. Embedded throughout our advocacy work at the local, state and federal level, is a commitment to confront proactively and address, through public policy, the health inequities and disparities that exist in our country. In addition to prioritizing policy goals to serve diverse and disparate populations, AHA also works to engage these individuals in its grassroots advocacy campaigns. Recruitment materials reflect diverse populations, advocates engaged in grassroots and media advocacy opportunities represent a diverse audience, and outreach is conducted through cultural health initiatives to engage a diverse audience.

If the American Heart Association (AHA) is to achieve its 2020 goals to reduce death and disability from cardiovascular disease and stroke by 20% and improve the cardiovascular health of all Americans by 20%, the association has to prioritize opportunities to address social inequities, issues specific to vulnerable populations (ethnic and racial minorities, those with low income or less education, children, blue collar workers) and the importance of removing barriers and obstacles for risk reduction and behavior change. Often the most disadvantaged members of the population have the greatest need for preventive screenings, health promotion, or programming and have the least access or are the most reluctant to participate in these opportunities. The fundamental causes of vulnerability are rooted in issues of daily life, most often beyond the scope of traditional public health so it will be important for the AHA to consider engaging with nontraditional partners to consider ways to reduce health disparities in communities.

The following list is a summary of some of the specific ways AHA advocacy addresses issues around health disparities and vulnerable populations.

- Support delivery system reforms throughout the continuum of care aimed at improved care coordination (including disease management, transitional care, hospice, and end-of-life interventions.) as well as initiatives aimed at supporting family caregivers of persons with cardiovascular disease and stroke.
- Support the development, implementation, evaluation, and dissemination of effective public health policies and programs to promote cardiovascular health and reduce the burden, disparities, and costs of cardiovascular diseases.
- Work to eliminate race, gender, and geographic disparities in health care.
- Address the adequacy of the healthcare workforce to meet the needs of disparate populations in underserved areas.
- Promote reporting on health care quality measures including by gender and ethnicity
- Advocate for additional research to determine how best to reach and engage underserved populations and optimize policy interventions for people of all races, age, ethnicities, educational attainment, and income levels.
- Support health plan coverage that includes essential health care services such as hospital and ambulatory care, prescription drugs, preventive services, emergency care, and rehabilitation.
- Eliminate financial barriers to preventive services in public and private health insurance plans
- Ensure that personalized healthcare services are accessible to everyone

- Remove barriers for rehabilitation and treatment of heart and stroke patients
- Improve access to preconception and prenatal care for women of reproductive age to reduce modifiable risk factors for CHD
- Protect individuals undergoing genetic tests from discrimination of any kind
- Strengthen nutrition standards in schools for meals and competitive foods and in all government nutrition assistance or feeding programs
- Establish sustainable funding for tobacco cessation/prevention programs that meet or exceed CDC recommendations.
- Assure comprehensive smoking cessation benefits in Medicare, Medicaid, and other health plans.
- Establish a National Heart Disease and Stroke surveillance unit to produce annual reports on key indicators of progress in the prevention and management of heart disease and stroke, including progress in disparate or vulnerable populations.
- Advocate for robust health promotion and obesity prevention programs in early childhood programs including Head Start.
- Address the issue of food economics so that healthy alternatives are less expensive and less nutritious foods cost more, bringing subsidies/incentives and other pricing strategies more in line with the AHA's Diet and Lifestyle Recommendations and the Dietary Guidelines for Americans.^{1,1}
- Advocate for healthy food retailing in underserved areas.
- Encourage the availability, affordability, and appropriate distribution of fruits, vegetables, fiber-rich whole grains, fish (especially fatty fish), and low-fat dairy products to at-risk or vulnerable populations.
- Support the creation of and sustain existing Offices of Minority Health (or Multicultural Health) and Offices of Health Equity in state health departments.
- Secure and protect public funding and state appropriations that support eliminating health disparities initiatives.
- Secure state-level public funding for the WISEWOMAN (or like) programs, which provide low-income, underinsured, or uninsured 40-64 year old women with the knowledge, skills, and opportunities to improve their diet, physical activity, and other life habits to prevent, delay, or control cardiovascular and other chronic diseases.

Stroke Advocacy

OVERALL STROKE SYSTEM COORDINATION

Advocacy efforts at the federal level in support of increased funding for MEDICAL RESEARCH and for HEALTH CARE REFORM and at the state level to implement STROKE SYSTEMS OF CARE help address the needs of current and future stroke patients across the entire continuum of stroke care, from awareness and primary prevention to rehabilitation and recovery.

Awareness & Primary Prevention	EMS & Pre-Hospital	Acute Care	Secondary Prevention	Rehab & Recovery	Continuous Quality
<ul style="list-style-type: none"> • Improve public/private insurance coverage of clinical preventive services • Public education campaigns 	<ul style="list-style-type: none"> • EMS transport protocols • Training for EMS personnel 	<ul style="list-style-type: none"> • Removing barriers to telestroke • Reimbursement for tPA • State funding to promote GWTG-Stroke and Primary Stroke Centers 	<ul style="list-style-type: none"> • Funding for CDC State Heart Disease & Stroke Prevention 	<ul style="list-style-type: none"> • Medicare therapy caps • Private health insurance coverage for medically necessary therapy 	<ul style="list-style-type: none"> • Add stroke quality measures to Medicare • Support of Coverdell Stroke Registry, state registries

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OBJECTIVE: The Global Youth Tobacco Survey (GYTS) in Brazil was developed to provide data on youth tobacco use to the National Tobacco Control Program. **METHOD:** The GYTS uses a standardized methodology for constructing sampling frames, selecting schools and classes, preparing questionnaires, carrying out field procedures, and processing data. The GYTS questionnaire is self-administered and includes questions about: initiation; prevalence; susceptibility; knowledge and attitudes; environmental tobacco smoke; cessation; media and advertising. **SUDDAN** and **Epi-Info** Software were used for analysis. Weighted analysis was used in order to obtain percentages and 95% confidence intervals. **RESULTS:** Twenty-three studies were carried out between 2002 and 2005 in Brazilian capitals: 2002 (9); 2003 (4); 2004 (2) and 2005 (9). The total number of students was 22832. The prevalence rate among the cities varied from 6.2% (Joao Pessoa, 2002) to 17.7% (Porto Alegre, 2002). **CONCLUSION:** The tobacco use prevalence rates in 18 Brazilian cities show significant heterogeneity among the macro regions. Data in this report can be used to evaluate the efforts already done and also as baseline for evaluation of new steps for tobacco control in Brazil regarding the goals of the WHO FCTC.

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BACKGROUND: Although the majority of smokers initiate smoking during their teenage years, significant rates of initiation occur among young adults. Adolescents are more price sensitive than adults, but little is known about the impact of tobacco taxation on smoking initiation among young adults. Using a longitudinal design, this study examined the impact of decreased cigarette price, resulting from tobacco tax cuts, on smoking initiation among Canadian young adults aged 20 to 24 years. **METHODS:** Using Statistics Canada's National Population Health Survey longitudinal file, this study examined young adults who did not smoke at baseline in 1994-1995 (n=636, representing over 1 million young adults) and who were reassessed at follow-up (1996-1997). Multivariable logistic regression analysis using bootstrap weights was conducted to estimate the impact of decreased cigarette price on smoking initiation. The analysis controlled for the potential confounding effect of sociodemographic and tobacco control variables. Sensitivity analyses were conducted. Price elasticity was estimated. Analyses were conducted in 2003 and 2004. **RESULTS:** Approximately 10% of young adults had initiated smoking at follow-up. Decreased cigarette price was significantly associated with higher smoking initiation (adjusted odds ratio per \$1 decrease for a carton of cigarettes=1.15, 95% confidence interval [CI]=1.01-1.32, p=0.042). Sensitivity analyses showed similar results. Price elasticity was 3.36 (95% CI=0.07-6.75). **CONCLUSIONS:** Young adults are sensitive to cigarette prices. Reductions in cigarette prices will lead to increased smoking initiation among this group. Tobacco taxation should be an effective strategy to reduce smoking initiation among young adults.

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