



American
Heart
Association.



FALL 2021

POLICY REPORT

Linking Scientists, Clinicians
and Policymakers to be a
Relentless Force for a World of
Longer, Healthier Lives.

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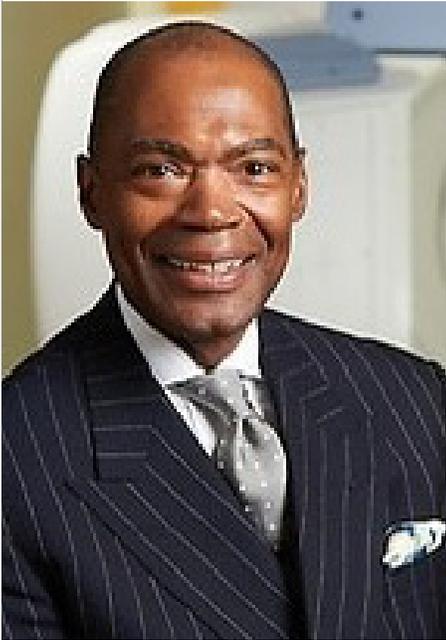
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LETTER FROM THE CHAIR

I am proud to share with you the Fall 2021 issue of the Policy Report.

In this edition, you will find the most recent policy publications that have been reviewed and approved by our Committee and now position the organization in important areas of policy. It is exciting that this year we are **Celebrating 40 years of Advocacy at the American Heart Association**. This first published policy statement details the arc of the organization's nonpartisan, evidence-based, equity-focused approach to advocating for public policy change and presents a vision and strategic imperative for future AHA advocacy efforts.

Additionally, we have recently published an important paper on **Maternal Health and Saving Mothers**. This Call to Action examines the alarmingly high rate of maternal mortality in the United States and suggests public policy actions to improve maternal outcomes.

The Importance of Strengthening the Public Health Infrastructure for Infectious and Chronic Diseases offers strategies to improve public health infrastructure to allow communities, states and the nation to engage in critical public health activities.

Transgender Youth: Addressing Access to Care and Sports Participation is a timely look at recent legislation targeting transgender children in the United States in the areas of access to care and sports participation and provides a call for gender-affirming and inclusive policies that protect individuals who are transgender.

Policy Levers to Improve Physical Education, Youth Physical Activity and Social and Emotional Learning offers results from in depth interviews with key stakeholder groups to reimagine our work in physical activity and physical education in schools which is especially important as we see the impact of the COVID-19 pandemic on children's rising levels of physical inactivity and obesity.

Our policy statement on **Paid Family and Medical Leave** discusses the equity and health impact of paid family and medical leave and advocates for updated and expanded paid leave policies.

Other statements are our new policy positions on **Systems of Care for ST-segment Elevation Myocardial Infarction**, and updated policy guidance on **Smoke-Free Policies in Multi-Unit Housing**.

As always, we welcome your response and feedback on this **Policy Report** to uphold the American Heart Association's mission to be a relentless force for a world of longer, healthier lives. Please continue to contact us at policyresearch@heart.org.

Sincerely,

Dr. Keith Churchwell, FAHA
Chair, Advocacy Coordinating Committee

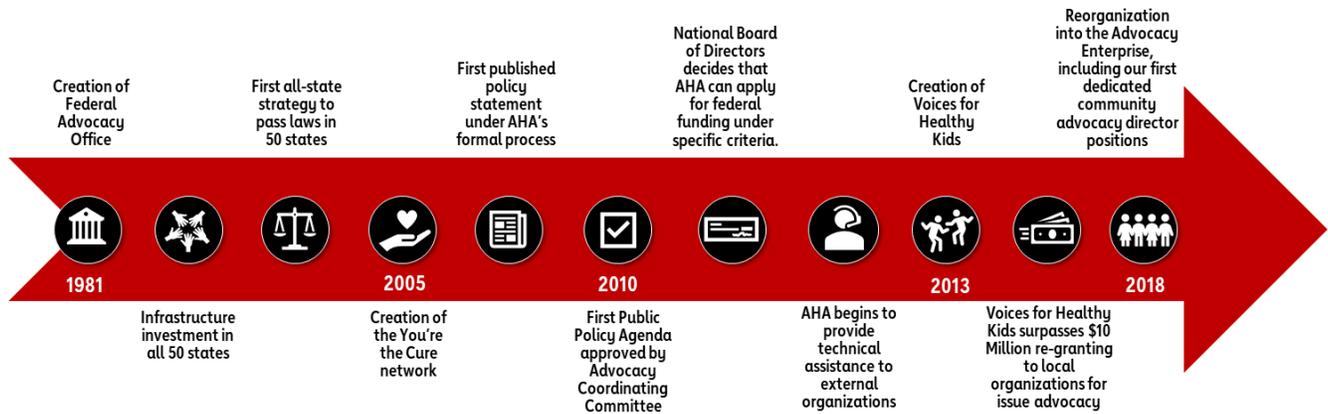
"Our equity-focused advocacy and policy work is more important than ever as we work to emerge from the COVID-19 pandemic and celebrate our 40-year commitment to advocacy at the American Heart Association."

HOW TO USE THIS REPORT

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



CELEBRATING 40 YEARS OF ADVOCACY AT THE AMERICAN HEART ASSOCIATION



In 2021, the American Heart Association (AHA) celebrates our 40th anniversary in advocacy. We have published a paper detailing the arc of the organization's non-partisan, evidence-based, equity-focused approach to advocating for public policy change, highlighting key milestones, and describing the core components of the association's capacity and activity at all levels of government. Importantly, the paper presents a vision and strategic imperative for future AHA advocacy efforts to inform and influence policy changes that advance equitable, impactful societal solutions that transform and improve cardiovascular health for everyone. The AHA will continue to develop policy implementation and outcome evaluation to assess for equitable health outcomes. The AHA will strive to apply these lessons learned to constantly refine its own strategic policy focus and advocacy efforts. The association also hopes to serve as a resource and catalyst to other organizations working to engage and educate policy makers, partners, the media and funders about the important role and contribution of public policy change to achieve shared health goals.

3 THINGS TO KNOW

1

The AHA opened its first Office of Public Advocacy in Washington, D.C. in 1981 focused on increasing federal research funding. The association's advocacy efforts continued to expand and grow in the 1990s as the AHA united under a single non-profit corporation, embraced a new strategic driving force, providing credible heart disease and stroke information for effective prevention and treatment, and included advocacy as one of four key areas of focus for the organization.

2

The American Heart Association now has a long, impactful organizational history advocating for public policy change. The organization is a global leader in advancing public health and translating research into evidence-based, equity-focused policy across a broad strategic policy agenda that transforms systems, environments, and delivery of care to achieve its mission.

3

The future of advocacy at the AHA promises to be both dynamic and different as well as principled and oriented to its values mission. It will remain science-based, equity-focused, and impact-oriented.



THE IMPORTANCE OF STRENGTHENING THE PUBLIC HEALTH INFRASTRUCTURE FOR INFECTIOUS AND CHRONIC DISEASE

3 THINGS TO KNOW

1

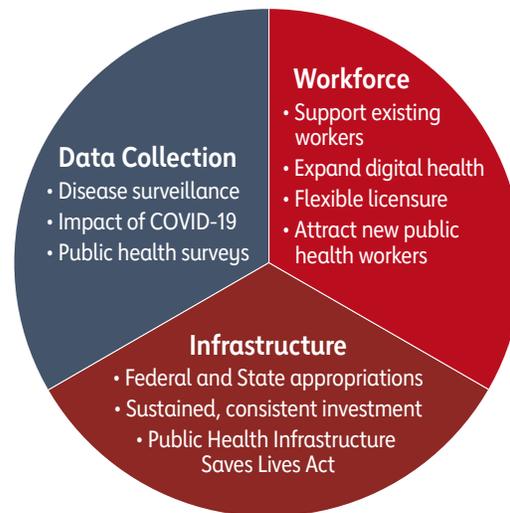
Reorienting the US health care system through value-based payment models to improve disease prevention and contain health care costs can maximize the existing workforce's impact on public health.

2

Poorer health across various communities that have historically been under-resourced, is not a coincidence, but a function of social determinants of health (SDOH), causing racial and ethnic minorities, individuals within the LGBTQ+ community, and those of lower socioeconomic status to bear a disproportionate burden of infectious and chronic disease.

3

The volume of data that must be collected and shared to effectively combat disease outbreaks has risen dramatically. The US requires more robust and secure data superhighways to ensure surveillance data are securely stored and are capable of being transmitted, in real-time, between interoperable agency systems.



The people, places, organizations, and systems that work in concert to protect population health represent the nation's public health infrastructure. A robust public health infrastructure allows communities, states, and the nation to engage in critical public health activities including prevention of and response to public health threats from infectious and chronic diseases to injuries and environmental hazards. Unfortunately, the federal, state, local, territorial, and tribal health agencies responsible for protecting the public's health have consistently lacked adequate funding to support the training, recruitment, and retention of a robust public health workforce, modernizing data collection and management, and implementing impactful and scalable long-term health promotion and disease prevention initiatives. As the COVID-19 pandemic underscores, the paucity of comprehensive, accurate, and timely public health data makes it difficult to effectively monitor public health trends, determine where public health interventions should be targeted, and evaluate their impact. AHA believes the strategies presented in this policy position statement have the potential to impact infectious and chronic disease outcomes for all people living in the United States.





CALL TO ACTION: MATERNAL HEALTH AND SAVING MOTHERS

Maternal mortality is alarmingly high at about 700 deaths a year in the United States (US), with cardiovascular disease the leading cause of pregnancy-related death. As such, the American Heart Association (AHA) has a unique role in advocating for efforts to improve maternal health and enhance access to and delivery of care before, during, and after pregnancy. Aligning with the AHA's mission "to be a relentless force for longer, healthier lives," this policy statement outlines the inequities that influence disparities in maternal outcomes, current policy approaches to improving maternal health, and suggests additional potentially impactful actions to improve maternal outcomes and ultimately save mothers' lives.

Several initiatives have shaped the time course of major milestones in advancing maternal and reproductive health equity in the US. There have been significant strides in improving timeliness of data reporting in maternal mortality surveillance and epidemiological programs in maternal and child health, yet more policy reforms are necessary. AHA recommends a multi-pronged approach to help reduce US maternal mortality rates and improve maternal health among individuals



experiencing pregnancy including: improving health literacy and public awareness on preconception care; achieving cultural competency and bias reduction among providers; mitigating the impact of social and structural determinants of health; transforming payment and promoting value-based care; modernizing healthcare delivery infrastructure and expanding care-coordination; improving public health infrastructure and digitally enabled healthcare; improving quality reporting of maternal outcomes and health metrics; and expanding access to quality postpartum care.

3 THINGS TO KNOW

1

Cardiovascular disease (CVD) is the leading cause of maternal mortality in the US, potentially accounting for more than 1 in 3 pregnancy related deaths.

2

Pregnancy-related mortality rates for non-Hispanic Black and American Indian/Alaska Native women are up to 2-3 times that of white women, and these disparities persist independent of socioeconomic variables.

3

AHA is committed to leveraging advocacy efforts and working with strategic partners to develop sustainable and impactful solutions for preventing maternal death and ensuring all individuals experiencing pregnancy can live healthy lives before, during, and after giving birth.



PAID FAMILY AND MEDICAL LEAVE



Paid family and medical leave (paid leave) refers to longer-term paid leave from work to manage a serious personal health condition (medical leave), care for a family member with a serious health condition (caregiver leave), or bond with a new child after birth, adoption, or placement in foster care (parental leave). Both employers and employees are economically impacted by paid leave policies. Research has shown that paid leave increases productivity, profits, retention, and employee morale, and decreases turnover.

As many as 23% of employed mothers return to work within 10 days of giving birth because of an inability to pay for living expenses without income. Employees with access to paid leave benefit by experiencing an increased level of wage replacement during leave and an increased likelihood that women will be working nine to 12 months after a child's birth, compared to women who take no leave. In addition to economic benefits, research has established that paid leave enhances child and parental physical and emotional health. For example, infant mortality rates are inversely correlated with the duration of paid family leave. Other health benefits include fewer low birthweight babies, fewer ER visits, fewer hospital readmissions for infants and mothers, higher rates of breastfeeding, a lesser likelihood of sending a sick child to school, longer parental lifespan, and improved mental health, as well as increased long-term achievement for children.

Recognizing the equity and health impact of paid family and medical leave, the American Heart Association advocates for paid leave policies that:

- Address medical leave, caregiving leave, and parental leave;
- Cover as many workers as possible;
- Offer sufficient wage replacement, ensuring lower-income workers have enough wage replacement to allow them to take advantage of paid leave policies;
- Offer sufficient time off to meet worker needs;
- Guarantee job protections and anti-retaliation protections;
- Allow gender neutral parental leave to promote gender equity in the workplace; and
- Ideally, include an education and awareness campaign.

3 THINGS TO KNOW

1

The United States is the lone developed nation that lacks a federal policy mandating paid leave.

2

In 2019, only 19% of civilian workers had access to paid family leave, and only 60% of employees in the U.S. have access to the unpaid leave protections from Family Medical Leave Act.

3

Access to paid leave is inequitable with 9% of the lowest quartile of earners having access to paid family leave and 30% of the highest quartile of earners having access. In addition, Black and Latino/Hispanic families have less access to paid leave than white families.





TRANSGENDER YOUTH: ADDRESSING ACCESS TO CARE AND SPORTS PARTICIPATION

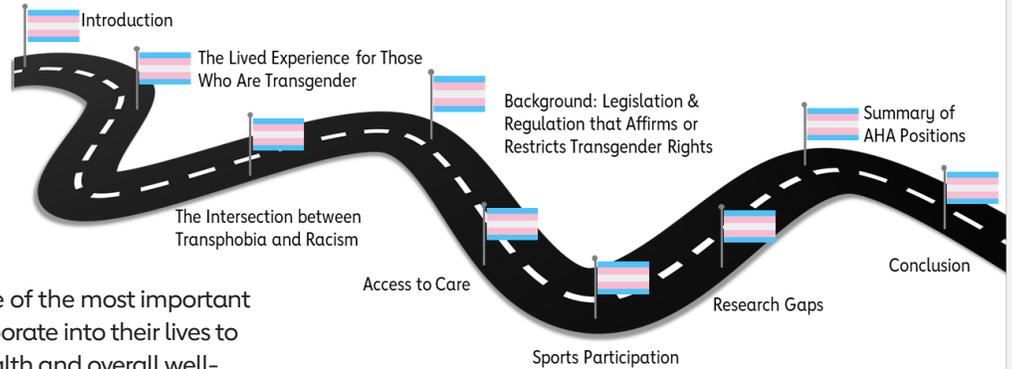
The American Heart Association believes every person deserves the opportunity for a full, healthy life and is committed to advancing cardiovascular health for everyone by identifying and removing barriers that stand in the way of this goal. Legislation is being introduced in states to limit access to care and sports participation for youth who are transgender. Physical activity is one of the most important lifestyle behaviors people can incorporate into their lives to improve physical health, mental health and overall well-being. Everyone, including children and adolescents, can gain the health benefits of physical activity. Given this, the American Heart Association supports efforts to eliminate policies that discriminate against participation in physical activity and sports participation based on sex, including sexual orientation or gender identity.

The American Heart Association also has a strong history of leading efforts to improve access to care in the United States. The Association believes that all efforts to create barriers to accessing care are harmful to patients and increase inequities. Care plans and treatments should be evidence-

based and determined by providers, patients, and their families, not by legislative or regulatory bodies. Transgender youth benefit from clinical care including mental health treatment and physical interventions that are gender-affirming. Access to care oriented to a patient's specific needs, including affirmation of gender identity or gender expression, must be preserved, and protected.

Fair and inclusive policies that protect transgender individuals and their health help ensure every person thrives and develops to their full potential.

Transgender Youth: Addressing Access to Care and Sports Participation Policy Guidance June 2021



3 THINGS TO KNOW

1

Because of socio-cultural traditions, pre-conceptions, or beliefs, those who are transgender are often “othered,” discriminated against and stigmatized. Youth who identify as transgender or gender diverse have an increased likelihood of mental health implications (anxiety, depression, body dysmorphia, self-harm, suicide), experiencing homelessness, domestic violence, sexual violence, substance use, high-risk sexual behaviors, and lack of affordable and culturally-competent care.

2

At the Federal level, the Biden administration is addressing equal access to healthcare and treatment for LGBTQ+ patients. This position is in line with a June 2020 US Supreme Court ruling that determined that the Civil Rights Act’s prohibition of employment discrimination on the basis of sex includes sexual orientation and gender identity. At the state level, states are taking varying approaches to transgender health – from protecting LGBTQ+ rights to limiting rights including access to health care or youth sports participation.

3

The American Heart Association believes every person deserves the opportunity for a full, healthy life and is committed to advancing cardiovascular health for everyone. The AHA supports efforts to eliminate policies that discriminate against transgender youth in access to care and sports participation.



SMOKE-FREE POLICIES IN MULTI-UNIT HOUSING

3 THINGS TO KNOW

1

An estimated 80 million Americans live in multi-unit housing properties (apartments, condominiums, and townhouses), representing about 1 in 4 people in the United States. In public housing, children and adolescents are 36 percent of residents while older Americans comprise 17 percent of residents.

2

As more states and localities have passed smoke-free air laws for public spaces and workplaces, the home has become the most significant source of exposure to second-hand smoke, especially for children. Despite progress on smoke-free air laws, an estimated 28 million Americans who reside in multi-unit housing are still exposed to second-hand smoke in their home or apartment.

3

Secondhand and thirdhand smoke exposure poses significant health risks to all residents in multi-unit housing residences.

The American Heart Association advocates for an end to tobacco and nicotine addiction in the United States, including policies that will limit exposure to secondhand smoke and vapor. Accordingly, the American Heart Association supports comprehensive smoke-free policies for public and private multi-unit housing. These policies should maintain access to housing with restorative approaches to enforcement and access to comprehensive cessation services. In public housing, these policies could be mandated as part of regulation since taxpayer dollars are used to subsidize the health and economic consequences of tobacco use. In privately-owned housing, legislation or regulation could provide incentives to owners such as insurance discounts, or funding for education, communication, and cessation resources as motivation to adopt comprehensive smoke-free policies.

Issue	American Heart Association Supports	Key Points
Comprehensive Multi-Unit Smoke-free Housing Policies	Comprehensive smoke-free multi-unit housing policies that ensure the complete elimination of secondhand and thirdhand smoke exposure, including electronic vapor.	<ul style="list-style-type: none"> • With the increased popularity of e-cigarettes and potential harm of e-cigarette vapor, nicotine vapor products need to be included in smoke free policies. • Secondhand and thirdhand smoke exposure poses significant health risks to all residents in multi-unit housing residency.
Comprehensive Multi-Unit Smoke-free Housing Policies Equitable Enforcement	Smoke-free multi-unit housing policies that promote cessation and other supportive approaches for violators of smoke-free policies rather than worsen existing disparities.	<ul style="list-style-type: none"> • Penalties for violations of smoke-free policies should focus on community-driven, cessation, and restorative strategies rather than punitive punishments. • Societal and structural factors should be considered when assessing for violations of smoke-free policies. • Promotion and access to tobacco cessation services should be a primary strategy when addressing policy violators.
Public and Private Multi-Unit Smoke-free Housing Policies	A comprehensive approach to smoke-free multi-unit housing which should include a variety of policy levers that address both publicly-, privately-owned, and mixed-financed properties.	<ul style="list-style-type: none"> • Comprehensive smoke-free policies should be implemented in all multi-unit housing, regardless of public or private, however policy levers may differ. • In public housing, smoke-free policies could be mandated as part of regulation and in privately-owned housing, legislation or regulation could provide incentives to owners such as insurance discounts, or funding for education, communication, and cessation resources as motivation to adopt comprehensive smoke-free policies. • These policies should maintain access to housing with restorative approaches to enforcement and access to comprehensive cessation services. • Private landlords, housing associations, and other housing authorities should consider community involvement, implementation and enforcement procedures for new and existing tenants, tenant communications, and costs associated with a comprehensive smoke-free policy.





POLICY LEVERS TO IMPROVE PHYSICAL EDUCATION, YOUTH PHYSICAL ACTIVITY AND SOCIAL AND EMOTIONAL LEARNING

With 130,930 K-12 schools across the country educating more than 55 million students, there is tremendous opportunity to impact child and adolescent health and well-being with effective policy levers around physical education and physical activity. Physical



activity before, during and after school, and active transportation to and from school are important ways children and adolescents can equitably access physical activity opportunities that are essential for their overall health and well-being. This is more important than ever with the impact of the COVID-19 pandemic on children's health, social, and emotional well-being. The Whole School, Whole Community, Whole Child Model and the Comprehensive School Physical Activity Plan (CSPAP) are fundamental for guiding policy change.

In 2020, the American Heart Association policy research team worked with a broad interdepartmental planning group to identify and conduct qualitative interviews with key stakeholder groups, including school board members, Boards of Education, administrators, principals, superintendents, chief diversity officers, physical education teachers, researchers, non-governmental organizations, the Centers for Disease Control and Prevention, and professional organizations to reimagine our work in physical education and physical activity in schools. We created a series of virtual semi-structured discussions encouraging innovative thinking where everyone could speak openly. We also distributed a survey through social media to gather grassroots feedback on the questions we were asking the stakeholder groups. Through continued feedback and revision, a white paper and recommendations were finalized in early 2021. The primary recommendations were:

- Promotion of a Comprehensive School Physical Activity Plan should supplant a narrow focus on physical education as the primary advocacy position.
- The role of the school physical educator should be modified to include responsibilities as the "school physical activity coordinator" which would include responsibility for implementation of CSPAP at the school level.
- State legislatures and education agencies should fund school districts to implement CSPAP, and funded districts should be required to appoint a district-level coordinator who will be held accountable for ensuring that the district properly implements CSPAP, linking to social and emotional learning objectives and integrating into the districts' strategic planning.

The policy guidance outlines numerous other recommendations around CSPAP infrastructure, training and collaboration, assessment and accountability, research and surveillance.

3 THINGS TO KNOW

1

Physical education and physical activity in schools provide important benefits to children's social, emotional, and physical health and well-being.

2

The global COVID-19 pandemic has had a significant negative impact on physical education delivery in schools, how physical activity opportunities are offered, and children's overall physical activity levels.

3

Legislatures and school districts should support through appropriations and implementation Comprehensive School Physical Activity Plans that are linked to social and emotional learning objectives and integrated into school districts' strategic plans.



SYSTEMS OF CARE FOR ST-SEGMENT ELEVATION MYOCARDIAL INFARCTION (STEMI)

The introduction of Mission: Lifeline significantly increased timely access to percutaneous coronary intervention (PCI) for patients with ST-segment elevation myocardial infarction (STEMI). In the years since, morbidity and mortality have declined, and research has led to significant developments that have broadened our concept of the STEMI system of care. However, significant barriers and opportunities remain. From community education to 911 activation and EMS triage, and from emergency department and interfacility transfer protocols to post-acute care, each critical juncture presents unique challenges for the optimal care of STEMI patients. This policy statement sets forth recommendations for how the ideal cardiac system of care should be designed and implemented to ensure STEMI patients receive the best evidence-based care at each stage in their illness.



The following are proposed nationally focused efforts to eliminate barriers in cardiac systems of care:

- Increase public awareness campaigns of heart attack signs and symptoms and the importance of calling 911.
- Develop 911 destination transport protocols by having Emergency Medical Services (EMS) agencies, Referring Hospitals and Receiving Centers work together.
- Adopt and implement prehospital Cardiac Catheterization Laboratory (CCL) activation and “Direct to Cath Lab” protocols when appropriate for STEMI Receiving Centers.
- Improve Door-In-Door-Out (DIDO) times by having STEMI Referring Hospitals and Receiving Centers work together with designated inter-facility transport providers.
- Develop and implement Regional Transfer for PCI protocols and processes.
- Present and discuss focused feedback with each member in the system of care.
- Increase participation in active regional STEMI Systems of Care including review of regional data and sharing best practices.
- Increase attention to cardiogenic shock and out-of-hospital cardiac arrest.

3 THINGS TO KNOW

1

Since launching the Mission: Lifeline STEMI program, over 85% of the United States (US) population is reported as being covered by a STEMI System of Care with 857 hospitals included in 92 Mission: Lifeline Regions.

2

Between 2008 and 2012, use of pre-hospital electrocardiograms (ECG) and time to treatment significantly improved in hospitals (n=485) and patients (n= 147,466) participating in Mission: Lifeline.

3

Among the barriers remaining in establishing the ideal STEMI system of care are local and regional challenges, resource and financial issues and no single US STEMI Registry.

