



SPRING 2016 POLICY REPORT

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

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 Chair, Advocacy Coordinating Committee



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“The American Heart Association has made tremendous strides with its work in policy research to help the Association achieve its 2020 impact goals of improving the cardiovascular health of all American’s by 20%, while reducing cardiovascular disease by 20%.”

LETTER FROM THE CHAIR

As chair of the American Heart Association’s Advocacy Coordinating Committee, I am pleased to announce this latest addition of our Policy Report.

Over the past two years, the American Heart Association has made tremendous strides with its work in policy research to help the Association achieve its 2020 impact goals of improving the cardiovascular health of all American’s by 20%, while reducing cardiovascular disease by 20%. This report highlights the recent policy development and published statements of our organization.

You’ll also notice a few changes to the Policy Report, which include a new design and color-coded table of contents that corresponds to each summary. The enhanced look integrates social media into each highlighted policy stance allowing you to Tweet the latest Association policy news using the hashtag #AHAPolicy. Linked text instantly takes you to the summary of your choice, while a convenient “3 Things to Know” on each page gives you the key takeaways. Making the report more user-friendly and functional will save you time as you quickly scan and share policy updates with colleagues and professional connections.

The goal of the American Heart Association’s policy research department is to boost its advocacy efforts at the federal, state, and local levels by providing relevant implementation science and translation across the Association’s policy portfolio. Recent policy statements covered in this issue include sodium levels in school meals, the impact of the Affordable Care Act (ACA) on hypertension treatment and control, community and school access to clean drinking water, the impact of recently-proposed regulations on workplace wellness programs, e-cigarettes and workplace policy, physical education in schools, and the influence of drug formularies on patient access to cost-effective treatments.

The Association also published statements that called for support of the full implementation of the National Physical Activity Plan, and comprehensively outlined the evidence base for the initiatives prioritized in our Strategic Policy Agenda to assess their overall effectiveness in helping the Association achieve its 2020 impact goals.

We appreciate your feedback on how we can continue to improve this report and communicate to various audiences our work in policy research. Contact us at policyresearch@heart.org.

Sincerely,

John Warner, MD
Chair, Advocacy Coordinating Committee

HOW TO USE THIS REPORT

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



EVIDENCE-BASED POLICY MAKING: ASSESSMENT OF THE AMERICAN HEART ASSOCIATION'S STRATEGIC POLICY PORTFOLIO



This paper provides an exhaustive review of the evidence base behind the American Heart Association's Strategic Policy Agenda. American Heart Association (AHA) public policy advocacy strategies are based on the organization's strategic impact goals. The writing group appraised the evidence behind AHA's policies to determine how well they address the Association's 2020 cardiovascular health (CVH) metrics and CVD management

indicators and identified research needed to fill gaps in policy and support further policy development.

“Clinical and population research are required to expand and strengthen the evidence base for the development of new policies.”

There were generally close alignment between current AHA policies and the 2020 CVH metrics and CVD management indicators. Certain specific policies, however, still lack a robust evidence base. For CVH metrics, the distinction between criteria for adults (age >20) and children (<20) were often not considered although policy approaches may differ importantly by age. For CVD management indicators, specific quantitative targets analogous to criteria for ideal, intermediate, and poor CVH are lacking and needed to assess progress towards the 2020 impact goals to reduce deaths from CVD and stroke..

New research in support of current policies needs to focus on the evaluation of their translation and implementation through expanded application of implementation science. Clinical and population research are required to expand and strengthen the evidence base for the development of new policies. Evaluation of the impact of targeted improvements in population health through strengthened surveillance of CVD and stroke events, determination of the cost-effectiveness of policy interventions, and measurement of the extent to which vulnerable populations are reached must be assessed for all policies. There should be additional attention paid to the social determinants of health. The AHA's public policy priorities are generally robust and well-aligned with its 2020 CVH metrics and CVD indicators. Continued policy development and overarching research strategies will inform future strategic planning efforts.



Cite #AHAPolicy

3 THINGS TO KNOW

1

Evidence-based policy making is a cornerstone of the American Heart Association's advocacy efforts.

2

This paper summarizes the evidence base behind the Association's strategic policy agenda and assesses alignment with the Association's 2020 impact goals.

3

The American Heart Association will continue to evaluate the impact of its advocacy work on population health, which will be strengthened by improved surveillance of CVD and stroke events, consistent analysis of the cost-effectiveness of policy interventions, and assessment of the extent to which health equity is addressed and vulnerable populations are reached.



IMPACT OF HEALTH INSURANCE EXPANSIONS ON NONELDERLY ADULTS WITH HYPERTENSION



The AHA continues to advocate for the improvement of the ACA’s coverage provisions. As the law evolves, the AHA remains vigilant in support of improvements that address conditions like hypertension. This paper modeled long-term effects of improved hypertension management rates among people ages 25-64 under the ACA on CVD prevalence and mortality rates. The researchers concluded that the increased hypertension management rates under the ACA are expected to lead to 111,000 fewer new coronary heart disease events, 63,000 fewer stroke events, and 95,000 fewer CVD-related deaths by 2050.

“With 78 million people – or one in three US adults – living with hypertension, expanding health coverage to include access to lifesaving prescription medication and preventive measures is crucial.”

With 78 million people — or one in three US adults — living with hypertension, expanding health coverage to include access to lifesaving prescription medication and preventive measures is crucial. The AHA recognizes the benefits of improved hypertension treatment made possible through the ACA in preventing up to 480,000 new coronary heart disease (CHD) and stroke cases by 2050. Access to insurance coverage and medical services and affordable care are important tenets of the AHA’s policy positions when considering CVD risk factors like hypertension.



Cite #AHAPolicy

3 THINGS TO KNOW

1

Based on this analysis, federal and state efforts to expand insurance coverage among nonelderly adults with CVD have yielded significant health benefits.

2

Ethnic and racial disparities in health outcomes are narrowed for hypertension patients with more insurance coverage.

3

The ACA improves hypertension management by increasing the number of people who can receive treatment.



THE NATIONAL PHYSICAL ACTIVITY PLAN: A CALL TO ACTION FROM THE AMERICAN HEART ASSOCIATION

The US National Physical Activity Plan (NPAP) is a collective effort by members of the National Physical Activity Plan Alliance to increase the level of physical activity among the general public. This paper details the scientific evidence in support of increasing physical activity at the population level in addition to the evidence establishing the public health burden associated with sedentary lifestyles. Further, it summarizes the NPAP's recommendations for policy and best practices, explains how the recommendations mesh with the AHA's 2020 impact goals for increasing physical activity, and calls for AHA members and volunteers to work cohesively toward the plan's complete implementation nationwide.



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INCREASING AND IMPROVING PHYSICAL EDUCATION AND PHYSICAL ACTIVITY IN SCHOOLS: BENEFITS FOR CHILDREN'S HEALTH AND EDUCATIONAL OUTCOMES

This statement underscores the importance of physical education as part of a well-rounded educational curriculum that supports children's academic, physical, and cognitive development. The statement summarizes the evidence behind key policy recommendations for physical education and physical activity in schools and will serve as the basis for the AHA's physical education advocacy campaigns at the local, state, and federal level. Summary policy recommendations include:

Mandatory physical education

- Planned, sequential K-12 physical education curriculum that adheres to national and state standards to implement physical education.
- Adequate equipment, facilities and student-teacher ratios.
- No waivers, substitutions or exemptions.
- Taught by licensed, certified physical education teachers.
- Annual professional development for physical education teachers that is specific to their field and integrates the public health model.
- No waivers for students with disabilities, but allow modifications or adaptations that allow physical education courses to meet the needs of disabled students.
- Fitness and cognitive assessment in physical education that is reported to parents for individual student progress and to the community and relevant state agencies in an aggregate manner.
- One hundred fifty minutes of physical education per week requirement in elementary school and 225 minutes per week of physical education in middle school and high school.

3 THINGS TO KNOW

1

The National Physical Activity Plan recommends a comprehensive array of policies, programs, and initiatives to increase physical activity at the population level.

2

Increasing physical activity at the population level requires coordination across governmental and non-governmental agencies, as well as for-profit and non-profit entities at the federal, state, and local levels.

3

All members of the American Heart Association should work at every level to advocate for the Plan's full implementation.



INCREASING AND IMPROVING PHYSICAL EDUCATION AND PHYSICAL ACTIVITY IN SCHOOLS: BENEFITS FOR CHILDREN’S HEALTH AND EDUCATIONAL OUTCOMES *(CONTINUED)*

3 THINGS TO KNOW

1

This policy statement updates the AHA’s position on physical education and activity in schools and is endorsed by the American Cancer Society Cancer Action Network and the American Diabetes Association. SHAPE America, the Centers for Disease Control and Prevention, renowned researchers and other health organizations helped inform this revised policy statement.

2

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.

3

This statement outlines policy recommendations for the amount of physical education in schools, accountability measures, professional development for teachers, adequate resources, curriculum, waivers/substitutions, and other opportunities for physical activity throughout the school day.



School-based physical activity

- Daily use of classroom physical activity breaks.
- An implemented school wellness policy that establishes requirements for physical activity and physical education.
- An active transportation policy to and from school.
- Daily elementary school recess for at least 20 minutes.
- A shared use policy that makes physical activity facilities available to the community during out of school time.
- Intramural/club/sports activities provided by the school or school district.

Assessment and accountability

- Fitness and cognitive assessment in physical education that is reported to parents for individual student progress and to the community and relevant state agencies in an aggregate manner.
- School-based comprehensive self-assessment of physical education programs and physical activity offerings using existing tools such as the Physical Education Curriculum Analysis Tool. The results of the assessment should be integrated into the school district or school’s long-term strategic planning and/or school improvement plan, and school wellness policy.



Cite #AHAPolicy



REDUCING SODIUM INTAKE IN CHILDREN: A PUBLIC HEALTH INVESTMENT

In 2015, Congress considered legislation that would have halted further decreases in school meal sodium levels in addition to the reductions that had already been achieved. Supporters of this legislation cited the need for more scientific research showing the health benefits of sodium reduction in children.

“Reducing sodium intake in children’s diet establishes a foundation for healthy eating and optimum cardiovascular health.”

90%

Percentage of U.S. children ages 6-18 years that eat too much sodium

1 IN 6

Number of children in the U.S. with raised blood pressure

10

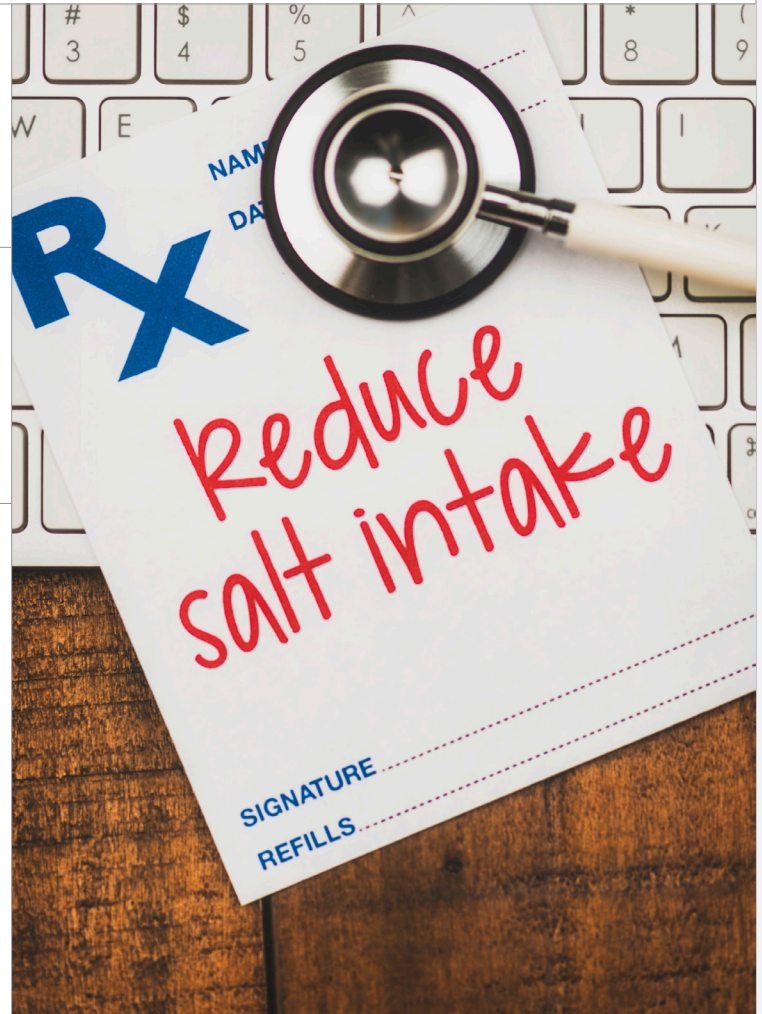
Number of foods that contribute 40% of sodium intake by children

Source: CDC

This policy statement details the scientific evidence that supports the health benefits of sodium reduction in children’s diets and the need for healthier school meals to improve children’s cardiovascular health.



Cite #AHAPolicy



3 THINGS TO KNOW

1

The seeds for hypertension are planted early in life.

2

Research strongly supports sodium reduction in children’s diets to reduce the likelihood of hypertension.

3

The American Heart Association strongly supports legislation that lowers sodium levels in school meal programs and supports measures that increase access to healthy foods for children.



INCREASING ACCESS TO SAFE DRINKING WATER IN SCHOOLS AND COMMUNITIES



The AHA supports a multi-faceted approach to address obesity by advocating for policies that improve availability and affordability of healthy foods and beverages. Communities are becoming increasingly aware that sugar-sweetened beverages lead to poor health outcomes. The AHA supports greater water consumption and access in schools and communities across the United States. This paper outlines policy recommendations that would achieve this goal. Further, it solidifies the AHA's efforts to advocate for free, safe, potable water to students and adults through policies that competitively price water and favor its

“The AHA supports greater water consumption and access in schools and communities across the United States.”

promotion over unhealthy beverages. Barriers associated with access to drinking water include awareness, safety, maintenance, and tax revenue (on bottled water). The AHA advocates for solutions that include greater community and school involvement, solid behavior-change strategies, active promotion, and free water access in strategic, public locations.



Cite #AHAPolicy

3 THINGS TO KNOW

1

Replacing sugar-sweetened beverages with healthier beverage choices like water can improve cardiovascular health.

2

The AHA supports greater water consumption and access in schools and communities.

3

Recommendations for increasing safe drinking water access include greater community and school involvement, solid behavior-change strategies, active promotion, and free water access.



JOINT CONSENSUS STATEMENT: A RESPONSE TO PROPOSED EQUAL EMPLOYMENT OPPORTUNITY COMMISSION REGULATIONS ON EMPLOYER-SPONSORED HEALTH, SAFETY, AND WELL-BEING INITIATIVES

This paper summarizes a consensus statement from multiple organizations and stakeholders on proposed rules released by the Equal Employment Opportunity Commission (EEOC) concerning the Americans with Disabilities Act (ADA) and Genetic Information Non-Discrimination Act (GINA) and worksite wellness programs. These proposed rules generated media attention and created a firestorm of public comment from employers, consumer groups, labor unions, and vendors.

The consensus process included review of existing and proposed regulations, identification of key areas where consensus is needed, and a methodical consensus building process. Stakeholders representing employees, employers, consulting organizations, and wellness providers reached agreement around five areas including adequate privacy notice on how medical data are collected, used, and protected; effective, equitable use of inducements that influence participation in programs; observance of reasonable alternative standards; what constitutes reasonably designed programs; and the need for greater congruence between federal agency regulations. Employee health and well-being initiatives that are in accord with federal regulations are those that take a comprehensive, evidence-based approach and are understood as voluntary by employees and regulators alike.



Cite #AHAPolicy

3 THINGS TO KNOW

1

Proposed regulation by the EEOC affecting worksite wellness programs created significant concern among various stakeholder groups including employers, consumer groups, and wellness providers about what the rules will mean for program and incentive design, the ability to access to quality, affordable health care, and employee privacy.

2

This paper summarizes a consensus process that convened multiple stakeholders and identified common ground.

3

The AHA is a strong supporter of comprehensive, evidence-based employee health and well-being initiatives that are in accord with federal regulations and are understood as voluntary by employees and regulators.





GUIDANCE TO EMPLOYERS ON INTEGRATING E-CIGARETTES/ELECTRONIC NICOTINE DELIVERY SYSTEMS INTO TOBACCO WORKSITE POLICY



As the use of e-cigarettes increases dramatically, employers wonder how to address e-cigarettes and other emerging tobacco products in the workplace. The American Heart Association, the Health Enhancement Research Organization, the American College of Occupational and Environmental Medicine, individual researchers, and other organizations came together to convene an expert panel to provide guidance to employers using the current science and evidence base. This guidance was published in the *Journal of Occupational and Environmental Medicine* in March 2015. Key highlights include:

- Employers should address e-cigarettes within their worksite tobacco policies and tobacco-free policies.
- They should include e-cigarettes in their tobacco-free work environments and ban e-cigarette use in smoke-free work areas. If they do have a designated smoking area, they should try to also establish a separate area for e-cigarette users. This will keep e-cigarette users safe from the second-hand smoke.
- When screening for tobacco use as part of a workplace wellness program, it is optimal to screen for both tobacco

and e-cigarette use, then tailor wellness programs and worksite policies accordingly.

- Employers should continue to offer comprehensive tobacco cessation services for employees who want to stop tobacco use, and allow e-cigarette users to access these services. Many e-cigarette users also use other forms of tobacco and can be helped by cessation support.
- If employers offer incentives to employees to achieve and maintain good health, target tobacco use instead of nicotine use as a measure. An incentive policy consistent with the ACA cannot require success at tobacco cessation, but may offer employees who use tobacco “reasonable alternatives” for meeting the tobacco-free measure. The alternatives most commonly include completion of a cessation program.
- Include education and awareness of e-cigarettes and cessation therapies in workplace wellness programs and publicize the workplace tobacco policy for employees, spouses and dependents. It’s especially important to reach children and adolescents, where education about e-cigarettes may prevent them from progressing to a nicotine habit.

Considering that the number of young people who report using e-cigarettes has dramatically increased in recent years, and the fact that this trend is expected to continue its rapid, upward trajectory, employers and public health experts have good reason to take note and be concerned about the future health of their workforce and communities.



Cite #AHAPolicy

3 THINGS TO KNOW

1

Employers are looking for guidance on how to incorporate e-cigarettes into worksite tobacco policy. Further research will continue to inform worksite tobacco policy.

2

This paper summarizes the current evidence base and expert consensus for e-cigarettes and smoke-free air policies, worksite screening, cessation services, incentive design and employee education.

3

In May 2016, the FDA finalized a rule extending its regulatory authority to cover all tobacco products, including vaporizers, vape pens, hookah pens, e-cigarettes, e-pipes, and all other Electronic Nicotine Delivery Systems (ENDS).



AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION STATEMENT ON DRUG FORMULARIES

3 THINGS TO KNOW

1

The Association's statement on drug formularies, which it uses to advocate on behalf of patients to ensure accessibility and affordability of pharmaceuticals, was recently updated.

2

The update focused on increased transparency of formulary information and improved communication of information to patients and prescribers.

3

The statement also included recommendations about the way that prior authorization could be improved to better address patient needs.

Drug formularies, or compilations of drugs or drug products in a drug inventory list, can be created by a healthcare facility, healthcare system, payer, or a third party. They are created via a formulary system whereby members of the healthcare system, working through the pharmacy and therapeutics committee, evaluate, appraise, and select from among the numerous available drug entities and drug products that are considered most cost-effective in patient care. Formularies are used by public and private payers, as well as healthcare facilities and systems, to delineate the pharmaceutical products that they will cover as part of enrollee health insurance.

The original statement on drug formularies was developed by the American Heart Association/American Stroke Association to guide its advocacy to ensure that pharmaceuticals are accessible to and affordable for patients. In November 2011, an expert panel was convened by the Association to update this document; a second update was conducted in March 2015 by the same panel.

The 2015 update includes several changes:

- Calls for transparency of information for the pharmaceutical products in the formulary, their tier and level of cost sharing, processes for changes or adjustments, and restriction strategies.
- Allows for electronic notification of the patient and the prescriber regarding the occurrence of therapeutic interchange.
- Requires 60-90 days notification of mid-year tier switches as well as the provision of information regarding alternatives that remain on the prior tier and information on the reason for the switch.
- Increases the statement's specificity around utilization control measures such as prior authorization, prescriber prevails, step therapy, and fail first.
- Recommends ways that prior authorization processes could be improved, standardized, and streamlined.



Cite #AHAPolicy



THE IMPACT OF DRUG SHORTAGES ON PATIENTS WITH CARDIOVASCULAR DISEASE: CAUSES, CONSEQUENCES AND A CALL TO ACTION

Shortages of cardiovascular drugs have become increasingly common, representing an ongoing public health crisis. Given few therapeutic alternatives to many of the drugs in short supply, these shortages also pose a major challenge for cardiovascular care professionals. Although changes in the regulatory environment have led to some improvements in recent years, problems involving

“Given few therapeutic alternatives to many of the drugs in short supply, these shortages also pose a major challenge for cardiovascular care professionals.”

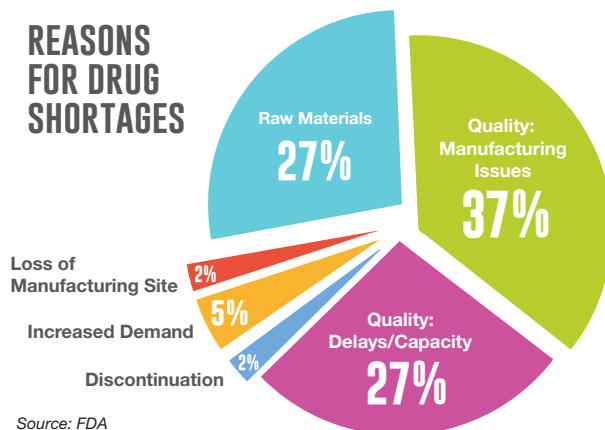
manufacturing processes remain the most common underlying cause. Due to the complex nature of drug shortages, sustainable solutions to prevent and mitigate them will require collaboration between regulatory agencies, drug manufacturers, and other key stakeholder groups. In this report, a writing group comprised of members from the American Heart Association/American Stroke Association describe the scope of the cardiovascular drug shortage crisis in the United States, including its underlying causes and the efforts currently being made to address it. It also provides specific recommendations for how cardiovascular care professionals can be involved in efforts to limit the impact of drug shortages on patient care as well as policy changes aimed at preventing and mitigating them.



Cite #AHAPolicy



REASONS FOR DRUG SHORTAGES



3 THINGS TO KNOW

1

The number of active drug shortages in the United States has increased by over 7-fold since 2007, and a growing number of these has affected patients with cardiovascular disease.

2

Although a promising downward trend has been observed in the number of new drug shortages reported each year, shortages of cardiovascular drugs have remained fairly constant.

3

A writing group comprised of members from the American Heart Association/American Stroke Association was convened to examine the issue of cardiovascular drug shortages and has issued a report that includes policy recommendations for future action.