



American
Heart
Association.



Summer/Fall 2020

POLICY REPORT

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

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LETTER FROM THE CHAIR

As Chair of the American Heart Association's Advocacy Coordinating Committee (AdCC), I am pleased to present to you the Summer/Fall 2020 issue of the Policy Report.

Many things have changed in our world since our last publication. One thing that has remained is the American Heart Association's steadfast resolve to ensure adequate, accessible and affordable healthcare for all in the face of a global pandemic — and our continued commitment to race and social justice.

In this edition you will find the most recent policy publications of the committee. The Report includes *Self-Measured Blood Pressure Monitoring at Home: A Joint Policy Statement from the American Heart Association and the American Medical Association* which reviews evidence in support of SMBP and offers policy guidance to adequately and equitably address barriers to implementation.

Basic Life Support Training for Healthcare Providers, reviews and comments on global disparities that exist in terms of access to basic life support training opportunities, the quality of available training and the likelihood of training implementation and quality improvement.

Creating Built Environments That Expand Active Transportation and Active Living Across the United States discusses the importance of safe, equitable active transportation policies in communities across the country to create healthier communities.

Our *Marijuana Policy Supplement* comes on the heels of our recent science statement and provides guidance in key policy areas related to cannabis as use is increasing considerably, especially in adolescents and young adults.

These statements and more make up one of our largest issues of the Policy Report to date. Even in uncertain times, the American Heart Association has pivoted our policy development and advocacy work with an equity framework and prioritized in the context of the COVID pandemic, making our efforts as relevant as ever.

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

Even in uncertain times, the American Heart Association has pivoted our policy development and advocacy work with an equity framework and prioritized in the context of the COVID pandemic, making our efforts as relevant as ever.

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.





SELF-MEASURED BLOOD PRESSURE MONITORING: A JOINT POLICY STATEMENT FROM THE AMERICAN HEART ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION



Improving the diagnosis, treatment, and control of hypertension is critical for achieving the American Heart Association's (AHA's) impact goals and improving the cardiovascular health of all Americans. Of the 85.7 million American adults estimated to have hypertension, nearly half do not have the condition under control, with many cases going undiagnosed. Ensuring accurate measurements across the care team is an essential component for improving blood pressure (BP) control rates. Self-measured blood pressure (SMBP) monitoring, defined as the regular measurement of BP by the patient outside of the clinical setting, either at home or elsewhere, shows significant promise for assisting in better hypertension diagnosis and management. The joint policy statement from the AHA and the American Medical Association serves as a review of evidence in support of SMBP and offers policy guidance to adequately and equitably address barriers to the implementation of SMBP monitoring.

To ensure the successful widespread implementation of SMBP monitoring, evidence supports financial investment in building and supporting infrastructure. This includes:

- improving education of patients and providers in the benefits of self-measured BP monitoring, device and cuff selection, and in the optimal approaches for SMBP monitoring.
- building health information technology capacity to facilitate the interaction between the patients, BP readings, and providers.
- incorporating self-measured BP readings into clinical performance measures.
- investment toward the incorporation of co-interventions along with self-measured BP monitoring.
- expanding coverage of services related to SMBP monitoring among private and public payers.
 - Patients should be reimbursed for the purchase of a validated self-measured BP monitoring device prescribed by their provider.
 - Providers should be reimbursed for costs associated with training patients including provider and staff time, transmission of BP data, interpretation of BP readings, and reporting; and costs of delivering co-interventions.

3 THINGS TO KNOW

1

The diagnosis and management of hypertension has been primarily based on the measurement of BP in the health care setting, however BP may differ considerably when measured in the office versus outside of the office setting. Out-of-office measurements provided through SMBP monitoring help ensure patients are diagnosed more accurately.

2

Best practices of SMBP monitoring include the use of validated devices with appropriately sized cuffs and a standardized protocol for BP measurement and monitoring.

3

Improving public and private health coverage of services related to SMBP monitoring and validated SMBP devices will be critical in ensuring widespread implementation of SMBP monitoring.



BASIC LIFE SUPPORT TRAINING FOR HEALTHCARE PROVIDERS

3 THINGS TO KNOW

1

Sudden cardiac arrest survival rates are low worldwide, particularly in developing countries.

2

Basic Life Support training (including CPR and AED use) for healthcare workers is a vital component of care systems worldwide.

3

Global disparities exist in terms of access to basic life support training opportunities, the quality of available training, and the likelihood of training implementation and quality improvement.



The global survival rate from sudden cardiac arrest (SCA) is less than 1%. Further, developing countries suffer from lower rates of SCA survival in comparison to their wealthier counterparts. This is due in part to the lack of mandated basic life support training for healthcare providers, which includes training in cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) use. Immediate high-quality basic life support (BLS) is a crucial step in the chain of survival and when delivered in compliance with existing evidence-based guidelines, is associated with improved patient outcomes. Therefore, training in BLS is a vital aspect of education for health care providers.

However, global disparities exist in terms of access to BLS and resuscitation training opportunities, the quality of available training, and the likelihood of training implementation and quality improvement. There is international recognition that the lack of adequate resuscitation training for healthcare providers is a major barrier to scaling up and sustaining emergency care services in many countries. Building on resuscitation treatment recommendations and guidelines previously published by international organizations, this policy statement sets forth guiding principles on the implementation, execution, quality improvement and oversight for CPR and BLS training for healthcare providers.





CREATING BUILT ENVIRONMENTS THAT EXPAND ACTIVE TRANSPORTATION AND ACTIVE LIVING ACROSS THE UNITED STATES

Active transportation is any mode of transportation that is powered by the human body, such as walking, biking, and using mobility assistive devices such as wheelchairs and walkers, and accessing public transportation. Active transportation is important because physical activity provides many benefits, including disease prevention, physical and mental well-being, and is crucial for optimal health. Many adults and children do not get enough physical activity in their daily lives. Only 26 percent of men, 19 percent of women and 20 percent of adolescents meet the aerobic and muscle-strengthening recommendations in the Physical Activity Guidelines for Americans. According to the World Health Organization, physical inactivity has been identified as the 4th leading risk factor for global mortality – causing 6 percent of deaths worldwide. The amount of physical inactivity globally has been described as a pandemic with widespread negative health, economic and social outcomes.

One of the leading, evidence-based strategies to increase physical activity across all ages, incomes, racial/ethnic backgrounds, abilities and disabilities is promoting active transportation through policy, systems and environmental change. However, most people in the United States, especially those living in communities that have historically been under-resourced, do not live in areas accessible to active transportation. This can limit an individual's access to economic and social opportunities.

Historical inequities in U.S. transportation and land use policies continue, with limited public investments in low-income communities to improve roads, sidewalks, lighting, and other transportation infrastructure.



Equitable transportation policies are those that support the development of accessible, efficient, affordable, and safe alternatives to car travel; encourage high-density, mixed-use, mixed-income development and affordable housing with good access to transportation options and employment for all communities. Various community stakeholders should be represented in planning processes, with an emphasis on engaging those who have been historically most disenfranchised.

3 THINGS TO KNOW

1

The American Heart Association supports safe, equitable active transportation policies in communities across the country that incorporate consistent implementation evaluation. Healthy neighborhoods may be defined as safe and socially-supportive, providing easy access to jobs and schools, healthy food, healthcare, social services and amenities, green open spaces, and public and active transportation options.

2

Improvements to transportation systems can include street layout and design, improvements to public transit infrastructure, and creation of bicycle and pedestrian facilities, which are improvements that make it easier for communities to accommodate, encourage and enhance opportunities for active transportation.

3

A Complete Streets approach requires that users of all ages, incomes, and abilities be considered in all roadway construction, repair, and routine maintenance.

MARIJUANA POLICY SUPPLEMENT

3 THINGS TO KNOW

1

Cannabis should be removed from its Schedule 1 categorization in the U.S. Controlled Substances Act to allow for more robust research and a more coordinated approach at the state and federal levels regarding marijuana regulation and legislation.

2

For states that do legalize cannabis, a robust public health infrastructure encompassing prevention, surveillance, counter-marketing and public safety is imperative.

3

The public health response should prevent access by minors; include robust enforcement around product integrity, sales tracking and food safety verification; ensure a competent and informed public health work force; protect third parties from unwanted consequences of legalized marijuana use; and leverage mass-market public awareness and education campaigns. Marijuana should be carefully integrated into comprehensive tobacco control and prevention efforts.

Marijuana, or cannabis, is the most commonly used illicit drug in the United States. Attitudes about its recreational and medicinal use have evolved significantly over the past 25 years, leading to legalization and decriminalization in a majority of states. The drug's potential therapeutic and medicinal properties come from its multiple compounds, particularly delta 9-tetrahydrocannabinol (THC) and cannabidiol (CBD). A recent AHA scientific statement comprehensively reviews the medicinal and recreational use of cannabis from a clinical and public health perspective by evaluating its safety and efficacy profile, particularly in relationship to cardiovascular health.

The consumption of cannabis products is increasing considerably, particularly among youth and young adults. Newer strains of marijuana are more potent, leading to risks including anxiety, agitation, hyperemesis syndrome, paranoia and psychosis. The U.S. Surgeon General has warned that recent increases in access to and potency of marijuana, along with misperceptions of the safety of marijuana, endanger youth, adolescents and the developing fetus. Under the 1970 Controlled Substances Act, marijuana is designated as a Schedule I drug with the highest level of control, a substance as having no safe medical use with a high risk of abuse or misuse. Schedule I substances are illegal under the law. However, as of May 2020, 33 states and Washington, D.C. have legalized marijuana for medical purposes, and 11 states and DC have legalized the drug recreationally, setting up a profound disconnect between state and federal law. The cannabis market continues to grow across the country. Legal sales topped \$12 billion in 2019 and are forecast to top \$30 billion annually within the next four years. In 2019, the legal cannabis industry employed nearly 250,000 people, a 15% increase from 2018.

This policy supplement provides additional guidance in key policy areas related to cannabis, including legalization, public health infrastructure, workplace safety/drug testing,



criminal and social justice, Food and Drug Administration (FDA) regulation of CBD in food and nutritional supplements, reducing youth use, school policy and expanding research at the federal and state levels.





NUTRITION STANDARDS IN SCHOOLS



For almost two decades, the American Heart Association along with other health and food security partners have advocated to improve the school meals program. In December 2010, the bipartisan Healthy, Hunger-Free Kids Act (HHFKA) was signed into law, which further empowered the U.S. Department of Agriculture (USDA) to update the national nutrition standards for school meals and establish nutrition standards for all other foods sold in schools throughout the school day. The updated nutrition standards have improved the nutritional quality of school meals and other foods and beverages sold in school and increased participation in the school meals programs. Yet, the USDA has proposed rolling back the nutrition standards in ways that would affect children's diets and their health, school meal participation, and school revenue.

Despite some growing pains and challenges, schools have stepped up to the plate and are serving more healthy meals than ever. To keep the school meals program strong and help ensure children living in the U.S. have access to nutritious food throughout the year, the American Heart Association will continue to advocate for:

- Robust school nutrition standards;
- Expanding access to the school meals programs—including programs over the summer and during school closures;
- Maintaining the integrity of and expanding the Fresh Fruit and Vegetable Program; and
- Supporting school nutrition staff to serve nutritious foods.

3 THINGS TO KNOW

1

Each day in the United States, nearly 30 million students receive lunch through the National School Lunch Program (NSLP), and more than 14 million students receive breakfast through the School Breakfast Program (SBP).

2

The NSLP is the nation's second largest food and nutrition assistance program, after the Supplemental Nutrition Assistance Program (SNAP), serving nearly five billion lunches in fiscal year 2019.

3

The NSLP and SBP are essential food security programs in the United States. The majority of student participants are from families with lower income —71 percent of NSLP participants and 85 percent of SBP participants receive free or reduced-price meals.

GENETIC COUNSELORS: IMPROVING ACCESS TO THEIR SERVICES FOR PATIENTS WITH CARDIOVASCULAR DISEASE AND THEIR FAMILIES

With the rapid evolution of the scientific evidence base in recent years that has shown the genetic influence on many cardiovascular diseases, genetic counseling has become a vital part of healthcare delivery. Research has shown that genetic counseling is important in identifying risk, the selection of appropriate tests, facilitating medical follow-up and providing support. Cardiovascular genetic data are now being integrated into healthcare protocols and clinicians are increasingly being asked to order cardiovascular genetic testing. Making sense of cardiovascular genetic risk, selecting the most appropriate test, and interpreting test results for a patient and the patient's family, are skills that require a deep understanding of medical genetics and appreciation of the limitations and benefits of the range of relevant cardiovascular genetic

tests available. However, most physicians are not sufficiently trained to determine the appropriate genetic test and interpret genetic information.

The dynamic nature of genetic testing necessitates the integral role of genetic counselors in patient evaluation and care. Genetic counselors are trained to expertly handle and interpret complex genetic information. Genetic counselors help CVD patients and their care teams understand their genetic profile and how it influences the care of patients and, in some cases, their family. However, genetic counselors are currently not reimbursed by Medicare for their services. This statement provides policy guidance that if enacted would ensure that all cardiovascular disease patients have access to the vital services of genetic counselors.



3 THINGS TO KNOW

- 1 Our knowledge of the genetic influence on cardiovascular disease has broadened significantly in recent years, leading to an increase in genetic testing.
- 2 Genetic counselors are vital members of a patient's care team who are trained to expertly handle and interpret complex genetic information and help patients understand their genetic profile and how it influences their care.
- 3 Genetic counselors should be reimbursed by Medicare for their services.



MEDICATION ADHERENCE: IMPORTANCE, ISSUES AND POLICY: A POLICY STATEMENT FROM THE AMERICAN HEART ASSOCIATION

Medications do not work in patients who do not take them. However, medication nonadherence has been documented to occur in over 60% of patients with cardiovascular disease (CVD), associated with poor control of risk factors and eventual progression of the disease. Additionally, medication nonadherence in chronic diseases results in up to \$300 billion of avoidable healthcare costs in the US annually accounting for 10% of total U.S. healthcare costs. The health and economic consequences of medication nonadherence can no longer be ignored and necessitates targeted efforts from policymakers and other stakeholders. As such, the American Heart Association and American Stroke Association have a goal of improving medication adherence in CVD and stroke prevention and treatment. In the context of healthcare, adherence is commonly described as the “active, voluntary and collaborative involvement of the patient in a mutually acceptable course of behavior to produce a therapeutic result.” Each patient may have a complex set of health beliefs, socio-economic difficulties, and other life circumstances that may influence their likelihood of adhering to their treatments as directed. In parallel, providers are as complex as the patients they care for. This paper explores medication adherence and its inherent issues in the context of four overlapping categories: patient-level, provider-health system level, cost, and system barriers. This paper also suggests several policy and structural changes that must happen at each level to reduce barriers to adherence and improve patient’s overall health to save lives from heart disease and stroke.

3 THINGS TO KNOW

1

Medication nonadherence has been documented to occur in more than 6 out of 10 patients with CVD.

2

According to the CDC, medication nonadherence in chronic diseases results in up to \$300 billion of avoidable healthcare costs in the U.S. annually, accounting for 10% of total healthcare costs.

3

In order to achieve a reduction in CVD deaths, medication adherence levels must be improved.



CALL TO ACTION TO PREVENT VENOUS THROMBOEMBOLISM IN HOSPITALIZED PATIENTS

3 THINGS TO KNOW

1

Acute venous thromboembolism (VTE), comprising deep venous thrombosis (DVT) of the legs or pelvis and pulmonary embolism (PE), is a frequent, costly complication in hospitalized patients, a leading contributor to increased length of stay, and the leading cause of preventable hospital death in the United States (US) and worldwide.

2

Most estimates place the US annual incidence of diagnosed VTE in adults at 1 to 2 per 1000 per year, increasing with age, obesity, and in Blacks. Provider and public awareness of VTE is low.

3

Primary prophylaxis in high-risk hospitalized medical and surgical patients is safe, clinically effective, and cost-effective for reducing VTE but is under-utilized.

Venous thromboembolism (VTE) is a major preventable disease that can affect patients who are hospitalized. Given that much of the morbidity and mortality from VTE is preventable, increased VTE awareness and prioritization of proven, evidence-based primary prevention strategies accompanied by uniform tracking of hospital-acquired VTE should be a national health priority. Treatment for acute VTE is estimated to incur direct medical costs of \$12,000 to \$15,000 (2014 US dollars) per individual in first-year survivors and between 10 to 30% of acute VTE survivors develop recurrent VTE within 5 years. The projected annual cost of preventable hospital-acquired VTE is \$7-10 billion per year.

Stratifying patients by their risk and taking preventive measures are extremely important. Barriers to these approaches currently exist that prevent their full adoption, compliance, and efficacy that has led to the persistence of VTE over the last several decades.

This policy statement provides a focused review of VTE, risk scoring systems, preventive measures for the hospital environment, and tracking methods. From this summary, five major areas of policy guidance are presented that the AHA believes will lead to better implementation, tracking and prevention of VTE events. They include 1) Performing VTE risk assessment and reporting the level of VTE risk in all hospitalized patients, 2) Integrating 'preventable VTE' as a benchmark for hospital comparison and pay-for-performance programs, 3) Supporting appropriations to improve public awareness of VTE, 4) National tracking of VTE using standardized definitions, and 5) Developing a centralized data registry for tracking VTE risk assessment, prevention, and rates.

