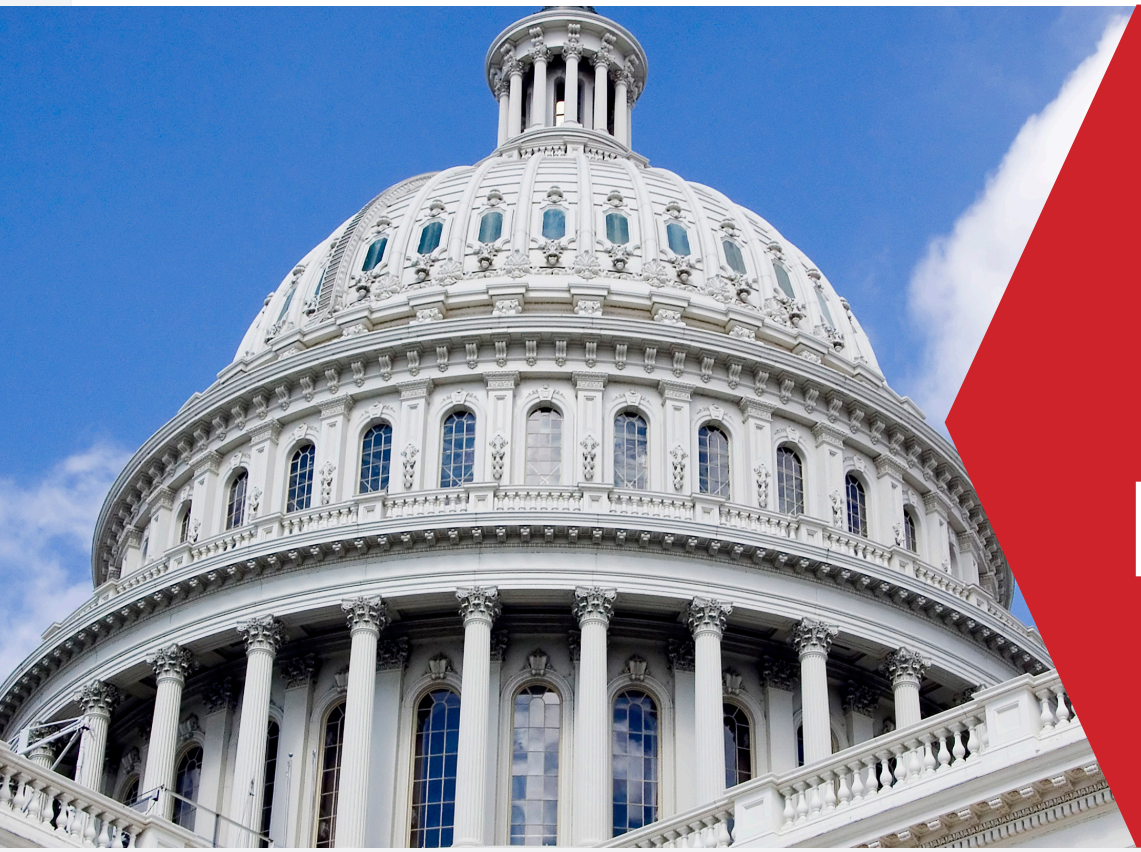
American Heart Association.

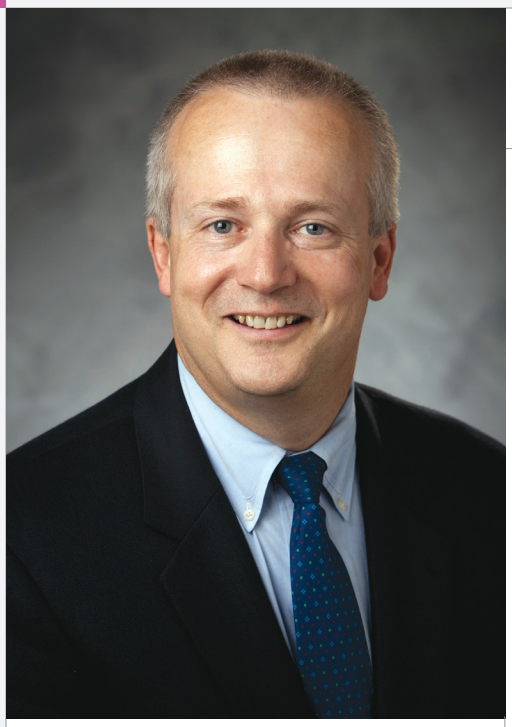


FALL 2018

POLICY REPORT

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

WHAT'S INSIDE



"To be a relentless force for a world of longer, healthier lives."

LETTER FROM THE CHAIR

As Chair of the American Heart Association's Advocacy Coordinating Committee, it is my pleasure to share this seventh issue of our Report. Recently, the American Heart Association launched a new branding campaign, along with a new mission statement: "to be a relentless force for a world of longer, healthier lives." In policy research and advocacy, we are working every day to be that relentless force translating science into impactful, equitable, evidence-based policy change.

In this edition you will find the four most recent policy publications of the department. The Report includes *Projected Costs of Informal Caregiving for Cardiovascular Disease: 2015 to 2035* which discusses the growing need for informal, or unpaid caregivers for aging Americans living with cardiovascular disease and stroke; and provides proposed policy solutions for federal, state and local government.

Next, you will find a case study describing the American Heart Association's Voices for Healthy Kids initiative with the Robert Wood Johnson Foundation and its important role in creating policy change through multi-sectoral collaboration and coordination. Voices for Healthy Kids was selected as one of 12 country case studies, brought together by the Partnership for Maternal, Newborn and Child Health (PMNCH), that showcase the advances being made in working across sectors to improve the health and well-being of children and adolescents.

The Importance of Community Health Workers for CVD Prevention and Treatment examines how trusting relationships with frontline public health workers help to facilitate access to care and improve quality and cultural competence for patients in their communities.

Finally, *Tiered Sugary Drink Tax Revenue Calculations* is a follow up to the November 2017 report *Distribution of Sugar Content in Sugary Drink Purchases in the U.S: Implications for Tiered Taxation* in which a tax revenue model estimates the potential tax revenue for the tiered approach and uniform volume approach in sugary drink tax campaigns across the United States.

As always, we welcome your response and feedback to this Policy Report, as well as all the work that we do to uphold the American Heart Association mission. Please continue to contact us at policyresearch@heart.org

Sincerely,

Robert Harrington, 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.

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PROJECTED COSTS OF INFORMAL CAREGIVING FOR CARDIOVASCULAR DISEASE: 2015-2035

With the aging of the U.S. population, caregiving requirements are expected to escalate markedly by 2035. In the United States, over 65 million people currently provide care for a chronically ill, disabled or aged family member. Older individuals prefer to stay in their homes and community rather than in a nursing home and they also prefer to receive care from a family member rather than from a home health aide. This report estimates the costs of informal caregiving for patients with CVD that informs policy development and can help address a growing crisis in caring for an aging population.

"CVD caregivers are at risk for their own health deterioration and burnout from the prolonged distress, physical demands, and costs."

Informal caregivers are most often family members or other relations, partners, neighbors, and friends who may or may not live in the same household and provide care without paid compensation. The term "informal" is frequently used to distinguish these unpaid caregivers from paid professional caregivers who provide formal home or community-based care or institutionalized care, but this type of caregiving is not informal or simple.

The costs of informal caregiving for patients with CVD were estimated to be $61 billion in 2015 and are projected to increase to $128 billion in 2035. Accounting for these costs increases total CVD costs by 11 percent to $616 billion in 2015 and $1.2 trillion in 2035. Costs of informal caregiving to stroke patients constitute more than half of the total costs of CVD informal caregiving ($31 billion in 2015 and $66 billion in 2035). At the per person level, the burden of informal caregiving of CVD is the greatest among blacks and persons ages 80 years or older.

The estimated projections of CVD for caregiving costs will provide data upon which a more cohesive and comprehensive set of health reform policies and practices can be designed to meet the specific CVD care needs, minimize the burdens experienced by informal caregivers, and address the total economic impact of CVD.

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3 THINGS TO KNOW

1. Informal caregivers play an essential part in maintaining the health and wellbeing of individuals coping with serious illness like CVD, and caregiving has become a critical issue of public policy.

2. Proposed policy solutions include paid family medical leave, tax credits, technical assistance, training and support services, and community-based demonstration programs funded through insurance plans that provide long term care services. State and local governments may provide programs and services supported by appropriations including assistance in finding programs and services, respite care for caregivers, and supplemental services such as a personal emergency response system, assistive technology, home-delivered meals, transportation, or home modifications.

3. As caregivers experience substantial stress and personally endure large social, economic and health care costs, studying how caregiving costs augment the burden of heart disease and stroke is of direct and central relevance to the assessment of CVD's impact.

VOICES FOR HEALTHY KIDS: POLICY CHANGES TO PROMOTE HEALTHY WEIGHT FOR ALL CHILDREN AND ADOLESCENTS IN THE UNITED STATES

3 THINGS TO KNOW

1. The Voices for Healthy Kids initiative models a multisectoral and multi-stakeholder initiative addressing the health and well-being of all children and adolescents in the United States.

2. A focus on equity in the initiative's processes, strategies, and activities has strengthened the collaboration and begun to remedy existing health disadvantages of target populations.

3. Community involvement and an ongoing commitment to regularly bring stakeholders together to engage and collect feedback is helping inform continuous improvement of the initiative.

American Heart Association. Robert Wood Johnson Foundation

MAKING EACH DAY HEALTHIER FOR ALL CHILDREN™

Voices for Healthy Kids

Voices for Healthy Kids is a multisectoral collaboration that seeks public policy changes to improve food and physical activity environments to promote healthy weight for all children and adolescents in the United States. Engaging and coordinating the initiative's many different stakeholder groups is complex and sometimes challenging, but key investments and strategies have led to enacted policy such as legislation or regulations ("policy wins") and other achievements.

This paper describes implementation of the multisectoral collaboration and key factors that have enabled and benefitted it, as well as some of the challenges the collaboration has faced and the outcomes. This example of multisectoral collaboration shows how organizations are responding to the society wide problem of an increased prevalence of child and adolescent obesity. The paper shares lessons learned from the initiative that may inform global efforts to improve health.

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THE IMPORTANCE OF COMMUNITY HEALTH WORKERS FOR CARDIOVASCULAR DISEASE PREVENTION AND TREATMENT

The American Public Health Association defines a community health worker (CHW) as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery... [and] also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy." A CHW may be a lay health worker, community health advocate, patient navigator, *promotor de salud*, or another care provider, and may be trained and certified in a particular area, such as chronic disease management education.

There is no single national or industry-established CHW education and/or certification policy. As of August 2017, twelve states do not recognize any CHW training programs or curricula in their state; four are in the process of developing standards for such programs; seven recognize but do not approve training programs in their state; and 26 have certified curricula and/or training program standards. Thirteen states certify CHWs, though most of these certifications are voluntary, and 11 are discussing or developing certification programs.

"CHWs play a particularly important role in health care because they are able to gain a level of trust that may be unattainable by traditional health care workers."

In all states, inconsistent funding remains a significant barrier to expansion of the CHW workforce. CHWs are often funded through grants or community programs with limited funding. Currently, few states reimburse CHWs through Medicaid, private plan reimbursement, or public employee plans; and none reimburse for CHWs' full scope of practice.

Through the provision of the numerous services they offer, a growing body of research demonstrates CHWs' positive impact on chronic disease outcomes, particularly among low-income and minority populations. Research demonstrates CHWs improve chronic disease management, enhance disease prevention and screening, and promote positive lifestyle behavior changes. CHWs need to be fully compensated, supported with appropriate training, and integrated into the health delivery team and systems of care.

Cite

#AHAPolicy

3 THINGS TO KNOW

1. The AHA supports the appropriate use of CHWs as part of a team approach to preventing and treating cardiovascular disease.

2. With an unparalleled ability to reach and support individuals in their homes and communities, CHWs play a vital role in supporting patient care, particularly in many underserved communities.

3. The AHA supports state-based efforts to develop and implement CHW training and certification requirements in chronic-disease care and management, to create governing bodies, and equip these workers with important skills and facilitate their incorporation into provider networks, and create payment for CHW services through Medicaid, private plan reimbursement, or public employee plans.

TIERED SUGARY DRINK TAX REVENUE CALCULATIONS

Building off the November 2017 report, *Distribution of Sugar Content in Sugary Drink Purchases in the U.S.: Implications for Tiered Taxation*,[1] and the University of Connecticut Rudd Center for Food Policy and Obesity Revenue Calculator for Sugary Drink Taxes,[2] researchers estimated the revenue impact of tiered sugary drink taxes versus a uniform volume-based approach (ex. penny per oz.). A tiered sugary drink tax categorizes sugary drinks into tiers based on their added sugars content and then levies the tax by volume.* The tiered approach taxes beverages with more added sugars at a higher level than beverages with less added sugars. For the purposes of these revenue estimates, the researchers used 3 tiers: tier 1 contained beverages with less than 5g of added sugars per 8-oz.; tier 2 contained beverages with 5g to less than 20g added sugars per 8-oz.; and, tier 3 contained beverages with 20g or more added sugars per 8-oz. The tax revenue model estimated potential tax revenue for the tiered approach and uniform volume approach for the year of 2018 for all U.S. states and 10 municipalities (counties/cities).

Researchers found that a tiered tax approach would lead to a greater reduction in sugary drink purchases. A 1c./oz. and 2c./oz. tiered tax would also generate more revenue than a flat penny per ounce approach. A tiered 2c./oz. and 3c./oz. tax would generate less revenue than a flat 2c./oz. tax due to drastic reductions in tier 3 beverage purchases.

A tiered tax should be implemented over a flat volume-based tax whenever possible, because it is predicted to lead to a greater reduction in sugary drink purchases and may also generate more revenue. The tiered tax of 2c./oz. and 3c./oz. is preferable to the 1c./oz. and 2c./oz. tiered tax because it is predicted to lead to a greater reduction in sugary drink purchases.

	1 cent/oz. Tax		1c./oz. and 2c./oz. Tiered Tax		2 cent/oz. Tax		2c./oz. and 3c./oz. Tiered Tax	
State	Per Capita Purchases, Gal./Yr.	Revenue	Per Capita Purchases, Gal./Yr.	Revenue	Per Capita Purchases, Gal./Yr.	Revenue	Per Capita Purchases, Gal./Yr.	Revenue
California	22.35	$916,266,521	18.86	$1,210,959,661	16.94	$1,389,278,476	13.46	$1,396,555,123
Georgia	35.38	$381,163,843	27.56	$492,281,568	25.30	$545,120,022	17.49	$487,245,876
Massachusetts	31.26	$221,088,971	24.54	$285,605,204	22.52	$318,545,060	15.81	$287,714,749
Minnesota	42.38	$242,754,541	31.87	$319,002,774	29.95	$343,110,273	19.46	$298,622,654
Texas	32.93	$971,751,526	25.69	$1,254,810,114	23.55	$1,389,760,361	16.32	$1,244,549,141

** Tier 1: Beverages with less than 5g. added sugars per 8-oz. with NO Tax Tier 2: Beverages with 5g. to less than 20g. added sugars per 8-oz. with 1 or 2 cents per oz. tax Tier 3: Beverages with 20g. or more added sugars per 8-oz. with 2 or 3 cents per oz. tax.*

[1] Powell, L.M., Andreyeva, T., Isgor, Z., Distribution of Sugar Content in Sugary Drink Purchases in the U.S.: Implications for Tiered Taxation. 2017

[2] University of Connecticut Rudd Center for Food Policy and Obesity, Revenue Calculator for Sugary Drink Taxes. Accessed September 5, 2018 at: http://www.uconnruddcenter.org/revenue-calculator-for-sugary-drink-taxes

Cite #AHAPolicy

3 THINGS TO KNOW

1. Tier 3 beverages account for about 2/3 of all sugary drink purchases by volume nationwide.
2. A tiered tax of 1c./oz. for tier 2 beverages and 2c./oz. for tier 3 beverages, is predicted to generate 30% more revenue and lead to significantly lower per capita purchases of sugary drinks than a flat 1c./oz. tax.
3. A tiered tax of 2c./oz. for tier 2 beverages and 3c./oz. for tier 3 beverages, is predicted to generate less revenue than a flat 2c./oz. tax due to a drastic reduction (up to 80%) in tier 3 beverage purchases.