



American
Heart
Association.



SUMMER 2022

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 proud to share with you the Summer 2022 issue of the *Policy Report*.

In this edition, you will find the latest policy publications that have been reviewed and approved by our Committee and now position the organization in important areas of policy.

Our recently published policy statement on *Strengthening US Food Policies and Programs to Promote Equity in Nutrition Security* provides scientific rationale for equitable and stable availability, access, affordability and utilization of nutritious foods for people living in the U.S. who are at risk of or experiencing food insecurity.

Strategies to Address Socioeconomic and Racial and Ethnic Disparities in Chronic Diseases by Incorporating Food and Nutrition Programs into the Primary Healthcare Setting addresses how the addition of nutrition services and healthy food prescription in the healthcare system can be utilized to help patients access and consume health foods.

Our policy statement on *Food Sustainability and the Farm Bill* offers policy recommendations for the 2023 reauthorization of the Farm Bill including protecting funding for and access to the Supplemental Nutrition Assistance Program and addressing diet quality and sustainability of the food system.

Improving Heart Health Through Value-Based Payment (VBP) is a collaboration between AHA and the Duke-Margolis Center for Health Policy that provides recommendations for how value-based payment models can support the implementation of care practices for providers and health systems along the VBP continuum.

Tobacco Retail Strategies focuses on policy interventions first outlined in the 2019 Tobacco Endgame Presidential Advisory and explores the evidence and equity impact of retail policy approaches in impacting public health and tobacco use prevalence.

The Misuse of Preemptive Laws and the Negative Impact on Public Health discusses how the aggressive use of preemption and unnecessary restriction of local policymaking has become an increasingly common legislative tactic that stands in the way of evidence-based policy-making.

Tobacco Retail Licensure: Environmental Scan Analysis of 50 United States is an environmental policy scan conducted by the AHA policy research team to explore existing tobacco retail licensure state laws and regulation to gain a better understanding of the tobacco retailer regulatory environment in the U.S..

Recently the American College of Cardiology, the American Heart Association and the Heart Failure Society of America released *Updated Guidelines on the Management of Heart Failure* which provide modernized guidelines intended to provide patient-centric recommendations for clinicians to prevent, diagnose and manage patients with heart failure and will inform our policy efforts for heart failure patients.

Finally, *Digital Health Lexicon and Program/Policy Evaluation Framework* is a dynamic and evergreen database that provides a glossary of terms and use cases for consensus terminology around digital health strategies and projects.

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

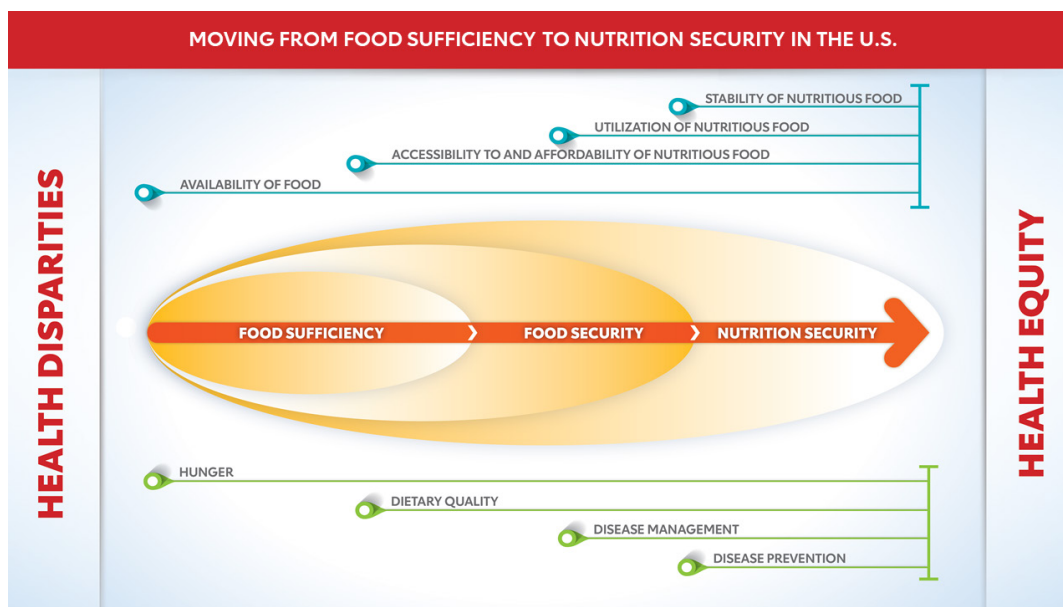
HOW TO USE THIS REPORT

- 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.





PROMOTING EQUITY IN NUTRITION SECURITY



Nutritionally inadequate dietary intake is a leading contributor to the development of chronic diseases. Food insecurity – a household level social or economic condition of limited access to sufficient food – is a common cause of inadequate dietary intake and has contributed to disparities in chronic cardiometabolic disease outcomes, especially cardiovascular diseases. Food insecurity has been a major issue in the United States (US) and affects at least one in 10 households, with higher rates consistently seen among households with children and Black households. While many US food policies and programs are designed to address food insecurity, there is growing consensus that this focus should be broadened to include nutrition security. Nutrition security is defined as having equitable and stable availability, access, affordability, and utilization of foods and beverages that promote well-being and prevent and treat disease. A focus on nutrition security is critical for addressing socioeconomic and racial/ethnic disparities in nutrition and chronic diseases.

The policy statement advocates for equitable and stable availability, access, affordability, and utilization of nutritious food for Americans who are at risk for or who are experiencing food insecurity and for the US Department of Agriculture to expand its measure of food security to include revised metrics for nutrition security. In the statement, the Association provides recommendations to expand and strengthen existing US food policies and programs and to develop and implement new policies and programs that promote equity in nutrition security and reduce nutrition-related chronic disease disparities. Applying the proposed recommendations in the statement to new and existing US food assistance policies and programs will move the US closer to achieving the Association’s goal to provide equitable, affordable access to healthy food for all.

3 THINGS TO KNOW

- 1** A focus on nutrition security, an individual household condition of having equitable and stable availability, access, affordability, and utilization of food and beverages over the life course, will ensure that all Americans can consume food that will prevent chronic disease.
- 2** US food assistance policies and programs provide an important opportunity to support nutrition security for a significant portion of Americans throughout the life course.
- 3** Coordinated and sustained efforts at the federal, state, and local levels along with advocacy, innovation, and research will be needed to expand US food policies and programs to improve cardiovascular health and reduce disparities in chronic disease.



ADDRESSING DIET QUALITY AND ENVIRONMENTAL SUSTAINABILITY IN THE FARM BILL



The Supplemental Nutrition Assistance Program (SNAP) is vital for addressing food insecurity in the United States. The program helps millions of Americans struggling through underemployment and low or stagnant wages. In March 2020, the onset of the COVID-19 pandemic resulted in sudden massive job loss and an increased number of Americans at risk for food and nutrition insecurity. As families struggled amid the pandemic, applications for SNAP benefits soared. In 2021, 41.5 million people participated in SNAP, up from 35.7 million people pre-pandemic, serving as an essential safety net during the pandemic and economic downturn.

Although diet quality has been steadily improving in the U.S. during the past two decades, overall dietary quality is still poor. Despite the important role SNAP plays in addressing hunger and poverty, additional data indicate that SNAP recipients have worse diet quality than income-eligible non-participants. Although diet quality for low-income consumers tends to be poor overall, studies have shown that SNAP beneficiaries consumed less fruit and vegetables and more added sugars and meat and meat alternatives when compared with income-eligible non-participants.

There is increasing public support for amending SNAP to add nutrition criteria to use government dollars toward healthful items to improve the health status of those with the greatest health disparities. Research has demonstrated that increasing the amount SNAP participants can spend on food does improve diet quality, correlating with increased purchase of fruits and vegetables, whole grains and dairy with less added sugar and fats..

There are also increasing concerns that current U.S. dietary patterns and food systems have a high environmental impact contributing to increased levels of greenhouse gas (GHG) emissions and water and land usage. The production and consumption of food are some of the main drivers of environmental degradation, threatening the

future availability of natural resources like land, healthy soil, and clean water. Foods in the U.S. are produced in a way that relies heavily on nonrenewable inputs and unsustainable practices. The production of ultra-processed foods and beverages as well as meat and dairy are responsible for the uptake in GHG emissions such as carbon dioxide (CO₂), with agriculture accounting for 10 percent of all GHG emissions in the U.S. and 24 percent of GHG emissions globally. These emissions contribute to climate change which threatens the availability of a healthy food supply in the future and puts healthy diets further out of reach for many.

The farm bill is a comprehensive multi-year bill that addresses agricultural and nutrition policy issues. Outlays for nutrition are about four-fifths of the full cost of the legislation and include SNAP and other nutrition programs. SNAP itself has an annual cost of approximately \$74 billion. As the U.S. continues to deal with the aftershocks of the COVID-19 pandemic and increasing concerns regarding the environmental impact of current dietary patterns, Congress needs to invest in policies that will improve the nutritional quality of food, diet quality, and ultimately the health for all people living in the US.

3 THINGS TO KNOW

1

A recent study found that 61 percent of SNAP participants viewed the cost of healthy food as a barrier to the adequacy of SNAP benefits.

2

Making changes to the SNAP program could lead to a spillover effect that improves diet quality for all Americans due to the role SNAP plays in determining what is marketed and sold in the retail environment.

3

To effectively address sustainability across the food system, the U.S. needs to provide significant investment and support to new and existing policies and programs that incorporate sustainable agricultural practices across the food system, minimize food waste, and ensure access to healthy, affordable food for all.





ADDRESSING SOCIOECONOMIC AND RACIAL AND ETHNIC DISPARITIES IN CHRONIC DISEASES BY INCORPORATING FOOD AND NUTRITION PROGRAMS INTO THE PRIMARY HEALTHCARE SETTING

Chronic diseases, such as cardiovascular disease, stroke, and diabetes, are some of the leading causes of death in the United States (U.S.). Underrepresented racial and ethnic groups, especially Black, Hispanic, and Native American/ Alaska Natives, are at higher risk for developing chronic diseases. For example, Black women and men have a higher prevalence of CVD than any other racial and ethnic group, at 58.8 percent and 60.1 percent respectively. Consuming an unhealthy diet, characterized by high intake of sodium, added sugars, and saturated fats, contribute to the development of chronic diseases. Stable availability, access, affordability, and utilization of nutritious foods across the lifecycle can help reduce the risk of chronic diseases and help treat and manage chronic diseases. Unfortunately, many individuals in the U.S. are food and nutrition insecure and do not have access to affordable, nutritious food. Incorporating recommended food and nutrition programs into delivery of healthcare is a viable option to help patients access and consume healthy foods.

There is increasing evidence that the healthcare system can be utilized to help patients with chronic diseases access and consume healthy foods. To address unhealthy diets and nutrition insecurity, key drivers of chronic diseases, evidence-based, cost-effective food and nutrition programs should be integrated into healthcare delivery. Nutrition services such as **Medical Nutrition Therapy (MNT)** and food and nutrition programs such as **food prescription programs** and **medically tailored meals (MTM)** are associated with reduced food insecurity, improved dietary intake, and



improved mental health. They also align with recent calls from healthcare-based interventions that address social determinants of health and achieve improvements in health equity. Combining nutrition counseling with food and nutrition programs has the potential to improve health and access to healthy food.

The American Heart Association supports efforts to increase equitable access to nutritious, affordable food in the healthcare delivery system and to connect under-resourced patients with community resources that will enable consumption of healthy eating patterns. Incorporating food and nutrition programs into the healthcare system is an effective strategy to prevent and treat chronic diseases, lower healthcare costs, and improve quality of life.

3 THINGS TO KNOW

1

In 2020, 10.5 percent of American households were food insecure, unchanged from 2019, but food insecurity rates were three times higher for Hispanic households (17 percent), Black households (21 percent) and households living at the federal poverty level (35 percent).

2

A growing body of research has shown that incorporating food and nutrition programs into the healthcare system is associated with improved health outcomes, reduced healthcare utilization and cost, and better-established patient-provider relationships in patients living with chronic diseases.

3

By increasing coverage for nutrition services through health insurers like Medicare and Medicaid and expanding existing programs, patients can be connected with the resources they need to prevent, treat, and manage chronic diseases.

IMPROVING HEART HEALTH THROUGH VALUE-BASED PAYMENT INITIATIVE

Value-based payment models (VBP) provide new payment approaches to encourage groups of providers to redesign and improve how care is delivered. The goal is for payment to reflect the value (better outcomes at lower cost) provided rather than the volume of services delivered by ensuring a focus on prevention and better management and coordination of care to achieve better outcomes and improve patient experience of care. These models can apply to a specific clinical condition, a care episode, or a population.

Recognizing the promise of VBP, the American Heart Association in partnership with the Duke Margolis Center for Health Policy and a national advisory council of respected experts from different backgrounds and perspectives, developed a comprehensive set of recommendations for the Center for Medicare and Medicaid Services Innovation Center (CMMI) in response to its strategy refresh. Here is a high-level summary of that white paper:



- Despite significant advancements in science, medicine, and technology, cardiovascular disease continues to be the leading cause of mortality and morbidity in the US and is on the rise.
- The burden of poor heart health falls disproportionately on communities of Black and Indigenous people.
- As long as a fee-for-service payment model remains the predominant method of payment for health care services in the United States, these trends are unlikely to be reversed, and health care services will continue to be fragmented and higher-cost with inequitable and suboptimal outcomes.

Value-based payment and care delivery models (also known as alternative payment models, value-based arrangements, value-based contracts, accountable care arrangements):

- have significant potential to enhance equitable cardiovascular health for all.
- are seen as a key pathway to improving care delivery for preventive services, such as risk factor screening, as well as management services for chronic diseases, such as heart disease.
- when compared to fee for service, provide greater flexibility in reimbursed services, supporting care teams and allowing clinicians to provide clinical and social services not traditionally reimbursed that can help maintain and restore heart health.

3 THINGS TO KNOW

1

Health equity, social determinants of health, and whole-person care must be key tenets of existing and emerging VBP models. Appropriate data and other supports must be provided.

2

A team-based approach to care delivery that also includes the patient, their caregivers, and community health partners, is essential for achieving better experience of care, and individual and population health outcomes.

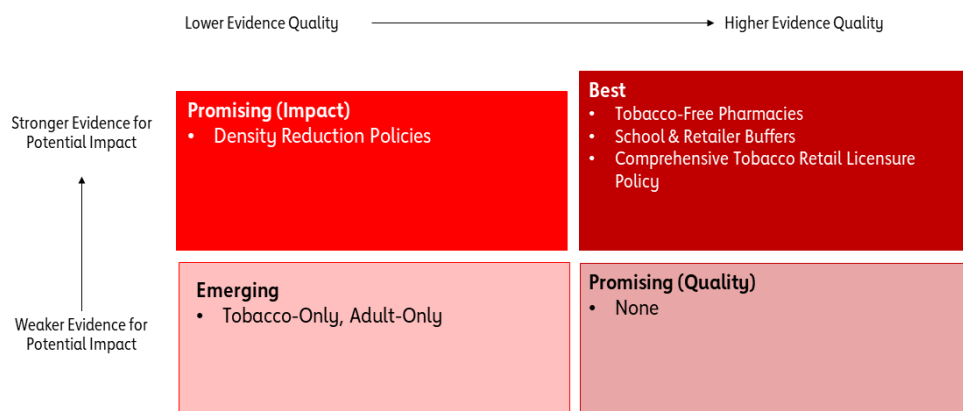
3

More and greatly enhanced coordination between primary and specialty care clinicians is critical to achieving effective whole-person cardiovascular care, integrating not just prevention and high-quality intensive care but also chronic condition management.



POLICY DEVELOPMENT AND ANALYSIS FOR TOBACCO RETAIL STRATEGIES

Summary of overall Quality and Impact of Component Evidence Assessment Results



important for informing this work. These three policy interventions are enhanced and can be utilized more effectively when combined with tobacco retail licensure laws that are already advocated for by the AHA. Though tobacco retail licensure laws were classified as “Best”, a secondary analysis found that “comprehensive” retail licensure laws (ones that require an annual fee that is renewed each year, all retailers have a license,

To assess evidence around public policy to address the number and location of tobacco retail outlets, the AHA’s policy research team, in coordination with leading experts, conducted a thorough review and analysis of the literature. The focus was on three primary policy approaches: (1) to restrict the location of tobacco retail outlets away from each other (retailer buffer) and away from youth-serving institutions and organizations (school buffer); (2) to reduce the density of retail tobacco outlets by reducing the number and density of retailers with a purposeful equity goal across different jurisdictions; and (3) to restrict the eligibility to sell through tobacco retail licensure (completely ending sales in local jurisdictions; limiting sales to adult-only, tobacco-only shops; or maintaining tobacco-free pharmacies and other health-related retailers). No studies included in the analysis evaluated the complete ending of tobacco product sales. The level of evidence for each strategy was determined by using the Quality and Impact of Component (QulC) Evidence Assessment and classified along the QulC evidence continuum.

There were three policies that were classified as “Best”, having strong potential for public health impact and high level of quality evidence and included: tobacco-free pharmacies, school and retailer buffers, and comprehensive tobacco retail licensure laws. Though classified as Best, tobacco-free pharmacy laws had the least equitable health impact. Despite this limitation, these laws had immediate effect when enacted. Second, the analysis found that 1000 ft school buffers and 500 ft retailer buffers are impactful policy interventions that effectively contribute to health equity. When sub-analysis was performed on the studies that explicitly focused on youth outcomes, the school buffer strategy had promising impact on public health with strong equity impact but continued research and evaluation, especially around implementation and industry tactics, will be

any violation is a violation of the license that have fines and penalties, and some combination of limiting the number of licenses (including retailer buffers), minimum pricing for cigars, age restrictions that extend to e-cigarette and nicotine delivery products (including school buffers), a ban on all flavored tobacco products, and/or tobacco-free pharmacy laws) had the strongest potential for a public health impact than the other policies and high levels of quality evidence. Effectiveness for a positive health impact and equity are strengthened because individual jurisdictions (state, county, city, etc.) can design the tobacco retail licensure law that best suits their community.

3 THINGS TO KNOW

1

The strongest tobacco retail strategy identified in this review and analysis was the use of 1000 ft. school buffers and 500 ft. buffer between tobacco retailers and would have significant equity impact and contribute to ending tobacco and nicotine addiction in the US.

2

The impact and equity of tobacco retailer strategies can be optimized when multiple strategies are combined as part of comprehensive tobacco retail licensing laws.

3

Comprehensive tobacco retail licensing laws can allow for more localized modification of the combination of strategies that best suit the needs of a particular community.



Cite



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THE MISUSE OF PREEMPTIVE LAWS AND THE NEGATIVE IMPACT ON PUBLIC HEALTH



Preemption is a legal doctrine that allows a higher level of government (federal or state) to restrict or remove the policymaking and enforcement power of a lower level of government (state or local). In and of itself, preemption is a neutral legal policy tool used to avoid conflicting laws across different levels of government. However, preemption has become an increasingly common legislative tactic used to strip local governments and elected officials of their regulatory power across a variety of issues.

While preemption is not new, its quantity, scope, and misuse have increased drastically in recent years, inhibiting responsive local public health policymaking on a wide range of issues. There are concerted efforts by special interest groups and corporate lobbyists to consolidate power at the state level and restrict local regulatory powers. There is a growing body of research showing that misused preemption has real and substantial consequences on health and equity, and the negative consequences of preemption are shown to disproportionately impact women, people of color, and communities with high rates of poverty, perpetuating systemic injustices.

The American Heart Association (AHA) advocates for equitable, science-based policy solutions at all levels of government. This policy statement recognizes the importance of local policy innovation to promote and protect public health and advance healthy equity and affirms the AHA's commitment to helping protect local governmental power and policymaking from the misuse of preemption.

3 THINGS TO KNOW

1

An increasing number of states are passing preemptive laws that limit the ability of cities and counties to create local laws related to issues as diverse as the tobacco endgame, nutrition standards, minimum wage, paid sick leave, and gun control.

2

Research shows that many corporate lobbyists push for state control of local issues in the interest of prioritizing business' profits and power over public health.

3

States that prohibit cities and counties from passing public health policies are more likely to have a population with higher prevalence of negative health outcomes.





TOBACCO RETAIL LICENSURE: ENVIRONMENTAL SCAN ANALYSIS OF 50 UNITED STATES

Tobacco Retail Licensure (TRL) is a key policy lever to decrease tobacco initiation among youth. The American Heart Association (AHA) is committed to ending all tobacco use and nicotine addiction in the U.S. and ensuring the next generation of youth do not become addicted to emerging nicotine products. TRL policies support this by requiring new and existing businesses to maintain a license before they are permitted to sell tobacco products.

Implementation of these policies can vary at the state, city, and/or county level with varying license requirements, fees, and penalties.

To gain a better understanding of the tobacco retailer regulatory environment in the U.S., the American Heart Association (AHA) conducted a 50-state scan of state policies, legislation, and regulations related to current tobacco retailers. Data collection and review focused only on the state level and did not include local community retail licensing policies or the collection of any data on local preemption. Data analysis was used to identify gaps in the retail licensure climate, to aid in the recommended development of stronger policies critical to controlling tobacco use and reduce disparities in how tobacco products are marketed. Findings from our assessment may better inform policy makers and tobacco endgame advocates to develop more comprehensive and effective tobacco retailer requirements and regulations. The results of this scan were developed into a database that can be accessed at tobaccoretaillicensure.heart.org.

Tobacco Retail Licensure Environmental Scan Analysis of 50 United States



40 states require Tobacco Retail Licensure



Licensing Fees across the US range from \$0-\$750

*Average Licensing Fee = \$120



23 states have Licensing Fees under \$100



Most states require licensing renewals every 1-5 years



Four states that require TRL do not require renewals of licenses.



Four states that require TRL do not have provisions for renewals



31 states require criminal or monetary penalties for Purchase Use Possession (PUP) Laws



States with such requirements are disproportionately located in Tobacco Nation (South and Midwest) and in states with large Native American populations

3 THINGS TO KNOW

1

Forty states identified as having a requirement for Tobacco Retail Licensure.

2

Overall findings indicate wide variances in state usage of license, as well as the amount of initial application fee and requirement for renewal.

3

There is no direct correlation between enforcement and penalty application—differences also apply to enforcement agency and state regulatory authority.



Cite



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UPDATED GUIDELINES ON THE MANAGEMENT OF HEART FAILURE

Recently the American College of Cardiology, the American Heart Association, and the Heart Failure Society of America published their Guideline for the Management of Heart Failure. Like the previous guideline published in 2013, the new guideline recommends that people who have some symptoms of heart failure (Stage C) participate in cardiac rehabilitation. Specifically, the two recommendations are as follows:

- For patients with heart failure who are able to participate, exercise training (or regular physical activity) is recommended to improve functional status, exercise performance, and quality of life and
- In patients with heart failure, a cardiac rehabilitation program can be useful to improve functional capacity, exercise tolerance, and health-related quality of life.

The guideline’s authors found high levels of evidence for the significant benefits of cardiac rehab.

However, too many people who are referred to cardiac rehab do not enroll for many reasons, one of which is the rehab facilities’ waiting lists. The Increasing Access to Quality Cardiac Rehabilitation Care Act would address this barrier by expanding and expediting access to cardiac rehabilitation. Improving access to cardiac rehab, particularly among women and people of color who are less likely to participate, is important, especially given that the guideline notes the racial and ethnic disparities in mortality and hospitalization for heart failure.

In addition, the guideline covers the use of sodium-glucose cotransporter-2 (SGLT2) inhibitors, a class of medications approved by the

Food and Drug Administration (FDA) to lower blood sugar in adults with type 2 diabetes that has also been studied in people with heart disease. These SGLT2 inhibitors show such benefit that they are mentioned in the first three of the guideline’s Top 10 Take-Home Messages. In addition, management strategies in stage C heart failure, including new treatment strategies such as SGLT2 inhibitors, is one of the five areas of focus in the guideline.

There has been significant excitement about SGLT2 inhibitors in the heart failure community, including at the AHA Scientific Sessions last November, and in recent years SGLT2 inhibitors have received approvals from the Food and Drug Administration (FDA). In fact, shortly before the 2022 guideline on heart failure was released, in late February, the FDA approved the SGLT2 inhibitor empagliflozin (with the brand name Jardiance) for all heart failure patients.

We are continuing policy development around cardiac rehabilitation coverage for all patients with heart failure, and assuring access to quality, affordable health care, including palliative care. We will be working on a coverage determination memo for the Centers for Medicare and Medicaid Services this Fall.





DIGITAL HEALTH LEXICON AND PROGRAM/ POLICY EVALUATION FRAMEWORK

Digital health is a complex field that leverages multiple technologies, often intermingled, to provide all manner of care to patients and populations. Most stakeholders do not fully understand the myriad terms, tools, and technologies involved. Due to the rapid evolution of digital health along multiple channels, many terms have come to be used in interchangeable or contradictory ways. This lack of consensus on terminology inhibits collaborative efforts across organizations and adds complexity to efforts to generate generalizable knowledge through evaluation and research.

The Digital Health Lexicon Project and Program/Policy Evaluation Framework is a dynamic, evergreen database consisting of a six-part glossary of terms, a section defining telehealth programs by typical characteristics, use cases, relevant cross-mapped CPT® (Current Procedural Terminology), and a resources section. The goals of this effort are to generate consensus terminology around digital health, streamlining internal communication and facilitating/informing AHA telehealth and digital health strategies and projects.



“The rapid evolution of digital health has led to definitions being utilized in interchangeable or contradictory ways; this lack of consensus inhibits collaborative efforts within and across organizations – adding complexity to efforts to generate generalizable knowledge through evaluation and research.”

3 THINGS TO KNOW

1

It is common when working in fields with rapid technological advancements to have a myriad of terms, tools, and technologies involved, leading to a lack of consensus on associated terminology.

2

The lack of a common lexicon in such fields often inhibits collaborative efforts across organizations and adds complexity to efforts to generate generalizable knowledge through evaluation and research.

3

The goals of the Digital Lexicon Project are to streamline internal AHA communication and facilitate AHA, enterprise wide, digital health strategies and projects.