













SUMMER 2023

# POLICY REPORT

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

## WHAT'S INSIDE

	<b>LETTER FROM THE CHAIR</b> Dr. Keith Churchwell Chair, Advocacy Coordinating Committee	<b>2</b>		<b>PHYSICAL ACTIVITY ASSESSMENT INTO THE US CORE DATA FOR INTEROPERABILITY (V.4)</b> <a href="https://bit.ly/USCDIV4">bit.ly/USCDIV4</a>	<b>8</b>
	<b>NUTRITION SECURITY STRATEGIC POLICY LANDSCAPE</b> <a href="https://bit.ly/AHANutritionSecurityLandscape">bit.ly/AHANutritionSecurityLandscape</a>	<b>3</b>		<b>TELEHEALTH PRINCIPLES</b> <a href="https://bit.ly/AHATelehealthPrinciples2022">bit.ly/AHATelehealthPrinciples2022</a>	<b>9</b>
	<b>WATER ACCESS POLICY STATEMENT</b> <a href="https://bit.ly/AHAWaterAccess2023">bit.ly/AHAWaterAccess2023</a>	<b>4</b>		<b>UPDATE TO CANNABIS STATEMENT</b> <a href="https://bit.ly/AHACannabisPolicyUpdate2023">bit.ly/AHACannabisPolicyUpdate2023</a>	<b>10</b>
	<b>AHA'S PROGRESS TOWARD ENDING ADDICTION FROM COMMERCIAL TOBACCO PRODUCTS IN THE US</b> <a href="https://bit.ly/AHATobaccoImpactStatement">bit.ly/AHATobaccoImpactStatement</a>	<b>5</b>		<b>VALUE-BASED PAYMENT FOR CLINICIANS TREATING CARDIOVASCULAR DISEASE</b> <a href="https://bit.ly/ClinicianVBP2023">bit.ly/ClinicianVBP2023</a>	<b>11</b>
	<b>TOBACCO SURCHARGE</b> <a href="https://bit.ly/AHATobaccoSurcharge2023">bit.ly/AHATobaccoSurcharge2023</a>	<b>6</b>		<b>EMERGING POLICIES THAT PROMOTE EQUITABLE, SAFE MOBILITY</b> <a href="https://bit.ly/AHAEquitableSafeMobility2023">bit.ly/AHAEquitableSafeMobility2023</a>	<b>12</b>
	<b>ADDRESSING CARDIAC REHABILITATION FOR PATIENTS WITH A CERTAIN TYPE OF HEART FAILURE</b> <a href="https://bit.ly/SupervisedExerciseTrainingforHFPEF2023">bit.ly/SupervisedExerciseTrainingforHFPEF2023</a>	<b>7</b>			



# LETTER FROM THE CHAIR

As the outgoing chair of the American Heart Association's Advocacy Coordinating Committee (AdCC), it is my pleasure to present you with the latest issue of our *Policy Report*.

This issue includes the most recent policy publications of the American Heart Association's policy research, including our newest policy statement, *Value-Based Payment for Clinicians Treating Cardiovascular Disease*, which considers the current state of new care delivery and payment models and offers recommendations for future improvements with a central focus on health equity.

We also include an update to our *Cannabis Policy* guidance which provides a review of the alarming uptake in youth and young adults and highlights the intersections between marijuana and tobacco public policy.

The association's recent Scientific Statement on *Supervised Exercise Training for Chronic Heart Failure with Preserved Ejection Fraction* shines a light on the need to include supervised exercise training (SET) in cardiac rehabilitation for HFpEF patients and serves as the foundation for a national coverage determination memo to the Centers for Medicare and Medicaid Services.

You will also find a report on the recent inclusion of *Physical Activity Assessment into the US Core Data Standards for Interoperability* (Version 4), that will require physical activity assessment as a core data element in electronic health records in the US. This measure standardization and interoperability requirement will help support patients on their journey toward active living.

In Fall 2022 the American Heart Association released our *Progress Toward Ending Addiction from Commercial Tobacco Products in the United States*. This progress report highlights the impact AHA has had by working with our national partners and leading campaigns.

An addendum to our *Telehealth Principles* as AHA continues to address the importance of integrating lessons learned from the COVID-19 pandemic to create sustainable solutions that integrate telehealth into health care delivery and optimize patient outcomes.

Our *Water Access Policy Statement* examines policies and strategies to promote consistency in water safety, quality and access at the state, local and federal levels for all people in the US.

Finally, we share our *Nutrition Security Strategic Policy Landscape* which provides our vision for nutrition policy and advocacy towards an equitable, sustainable food system that ensures nutrition security for all.

I am honored to be selected to serve as the American Heart Association's next president-elect and have enjoyed the opportunity over the past four years to contribute to the Association's advocacy efforts and successes as chair of the Advocacy Coordinating Committee. I look forward to opportunities to continue to support our important public policy work as I assume my new volunteer leadership roles and welcome your advice and support.

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 heart 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.

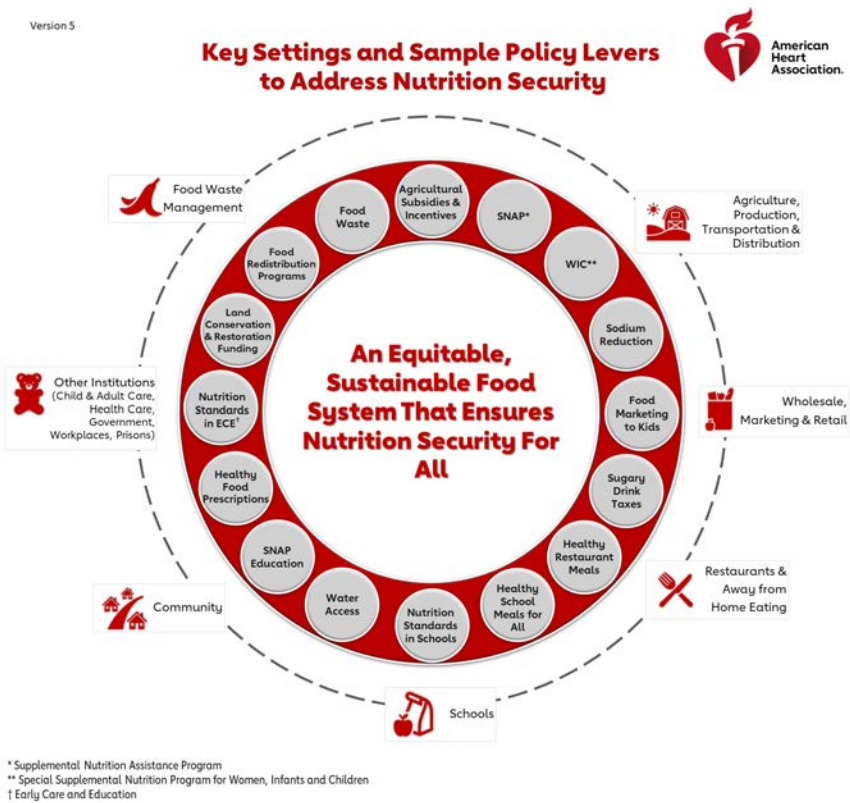


# NUTRITION SECURITY STRATEGIC POLICY LANDSCAPE

Despite steady improvements in Americans’ diets across the last several decades, overall diet quality remains poor in the United States. Nearly half (47.8%) of all American adults have poor diet quality, with higher rates found among Black (55.5%) and Mexican American households (48.8%). Poor diet quality is a major risk factor for developing chronic diseases such as coronary heart disease, stroke, and type 2 diabetes.

For certain populations, specifically those with lower incomes and communities of color, a healthy diet may be less accessible. Lack of access to affordable, healthy food makes adhering to a healthy diet difficult for people already living with chronic diseases, particularly for those experiencing food and nutrition insecurity. In the U.S., 10.5% of households are considered food insecure and the public health community has historically prioritized addressing food insecurity. However, there is a growing consensus that focusing solely on food security is too narrow an approach to improve health and wellbeing and reduce health disparities. The American Heart Association recognizes the need to shift the current narrow focus from food security – having enough calories – to a broader focus on nutrition security – having enough *nutritious* food – to address diet-related chronic diseases.

To achieve nutrition security in the U.S. and increase the impact of our work at AHA, there needs to be coordinated efforts across all levels of government and with other sectors, such as the research community, policy makers, and the food and beverage industry. AHA has developed a strategic vision for nutrition policy and advocacy – *an equitable, sustainable food system that ensures nutrition security for all* – which will inform how we approach our work through the end of the decade.



\* Supplemental Nutrition Assistance Program  
 \*\* Special Supplemental Nutrition Program for Women, Infants and Children  
 † Early Care and Education

## 3 THINGS TO KNOW

- 1 Unhealthy diets are a major cause of chronic disease including coronary heart disease, stroke, type 2 diabetes, and obesity.
- 2 To achieve nutrition security in the U.S. and increase the impact of our work at the Association, coordinated and sustained efforts across all levels of government— federal, tribal, state, and local —and other industries, such as public health organizations, philanthropies, the research community, and the food and beverage industry.
- 3 AHA’s Strategic Vision for Nutrition Policy and Advocacy defines how we will approach our nutrition-related work through the end of the decade. The strategic vision is grounded in nutrition security as a means of chronic disease prevention and treatment and health disparities reduction. In recognition of the serious impact of both health equity and environmental sustainability on nutrition security, we identify these as core elements of the vision.



# WATER ACCESS POLICY STATEMENT



Water plays a critical role in helping the body function including regulating temperature, protecting sensitive tissues, transporting nutrients, and ridding the body of waste. Drinking water protects muscles, joints, and tissues; improves the digestive system; and keeps the body hydrated. Increasing consumption of water, particularly as a substitute for sugary beverages, can lead to lower calorie intake, improved overall health, and a lower risk for obesity. Unfortunately, more than half of all U.S. children and adolescents and a third of U.S. adults do not drink enough water. On average, U.S. children and adolescents drank 23 ounces (about 3 cups) of plain water daily, and U.S. adults drank 44 ounces (roughly 5 ½ cups).

Inequitable access to safe and clean water contributes to inadequate hydration. Water security refers to having an appropriate quantity and quality of water available, accessible, and reliable for all domestic uses. Several US policies and programs, such as fracking, a drilling method for extracting oil, natural gas, or water from deep underground, and redlining, the practice of concentrating Black and other people of color into certain neighborhoods, have contributed to disparities in water access and quality within different geographies and communities with more Black and Brown residents. The American Heart Association (AHA) supports initiatives that increase access to, and promotion of safe and appealing drinking water, policies that price water at lower cost than sugary beverages, and policies that favor the promotion of water over the promotion of unhealthy beverages across all levels of government.

## 3 THINGS TO KNOW

1

Increased consumption of water, as a replacement for sugary beverages, can lead to lower calorie intake, improved overall health, and a lower risk of obesity.

2

Black children 1.34 times and Hispanic children are 1.23 times less likely to drink enough water each day when compared to white children. This is partially due to the fact that Black and Hispanic children are more likely to reside in communities and attend schools with less access to safe, clean drinking water.

3

AHA is committed to leveraging advocacy efforts and working with key stakeholders to implement policies across all levels of government to increase access to, and promotion of safe and appealing drinking water.



# AHA'S PROGRESS TOWARD ENDING ADDICTION FROM COMMERCIAL TOBACCO PRODUCTS IN THE US

Tobacco use remains a leading preventable cause of death, disease and disability, despite decades of progress from public health organizations seeking to control these deadly products and educate consumers of their dangers. Now, the AHA is committed to an even more aggressive goal: ending addiction from commercial tobacco and nicotine products. The AHA works at all levels of government to address tobacco use and this impact report highlights the progress that has been made since the AHA began advocating for public health policy more than 40 years ago.

The progress report highlights the impact the AHA has had by leading over 3,000 campaigns at the state and local levels, and the successful advocacy at the federal level. For example, through decades of work, the American Heart Association and its partners have helped pass comprehensive smoke-free laws, protecting people from secondhand smoke, reducing commercial tobacco use and saving lives. Because of these efforts more than 200 million people in the United States are now protected by comprehensive local and state smoke-free air laws. Another example is our work with state and local campaigns to raise the minimum sales age for tobacco to 21, which directly influenced the passing of legislation by Congress to raise the federal minimum sales age to 21.

Since the AHA established a federal advocacy office in 1981, addressing tobacco and public health has been a priority. Federal level wins over the years have included such transformational accomplishments as giving FDA regulatory authority over tobacco products, establishing smoke-free policies in public housing, eliminating smoking and use of tobacco products during air travel, and raising the federal excise tax on tobacco products. The American Heart Association's

## Adult Cigarette Consumption in the U.S.

Consumption Estimates are in Billions of Cigarettes



1900-1960: <https://www.statista.com/statistics/261573/total-cigarette-consumption-in-the-us-since-1900/> (accessed 12/13/21)

continued federal work includes actively defending the FDA's decisions to deny marketing orders of premarket tobacco

*"With the help of the AHA team, I learned not only how dangerous cigarettes are, but also how flavored tobacco products help get kids hooked."*  
 – Meet a Survivor: Kristen O'Carroll

applications and supporting the FDA's proposed rules to remove menthol cigarettes and all flavored cigars from the market.

## 3 THINGS TO KNOW

- 1 A goal of the American Heart Association's tobacco end game work is to cut tobacco use to less than 5% across the U.S. by 2035. That plan includes prioritizing reduction of smoking by 2030 and continuing to focus on ensuring e-cigarettes and other newer products don't addict the next generation of children and adolescents.
- 2 Between 2019-2021, the AHA ran 116 state and local advocacy campaigns addressing such policies as excise taxes, flavored product bans, comprehensive smoke-free air, comprehensive coverage of cessation programs, robust tobacco retail licensure laws, and many others.
- 3 Our endgame efforts have made a difference! We are reducing tobacco use across the U.S. population and globally. California has seen a decline in adult cigarette smoking from about 17% in 2001 to about 6% in 2022. Additionally, current use of any tobacco product by high school students in California decreased from almost 14% to almost 7% (decreases seen in virtually all products, including vaping).

# TOBACCO SURCHARGE

The Affordable Care Act (ACA) provides protection from higher premiums and other charges for insurance related to medical history or gender, but insurers can adjust premiums for age, tobacco use, and geography.<sup>1</sup> The smoking surcharge was included, in part, to recognize the individual responsibility for ongoing tobacco use. The ACA allows premium surcharges of up to 50 percent higher than the premiums of non-tobacco users. A surcharge at this level can make insurance unaffordable for many who use tobacco and their families. Most states implemented strategies intended to minimize disruption in the health insurance market and premium shock – particularly for those who were previously uninsured.<sup>1</sup> Fewer states, however, strengthened consumer protections around surcharges.<sup>1</sup> Several states elected not to initiate the surcharge and others limited the surcharge to something less than the 50 percent maximum.<sup>2,3</sup>

The position of the American Heart Association has been that if health plans include tobacco surcharges, then consumer protections must be integrated that prevent these surcharges from becoming overly coercive or reduce access to equitable, affordable, health care.<sup>4,5</sup>



The findings from the updated review indicate that there remains very little published data on the effectiveness of tobacco surcharges. Studies generally suggest that, with appropriate consumer protections, tobacco use surcharges may be effective in increasing rates of cessation. However, the use of tobacco surcharges without consumer protections reduces equitable access to affordable, quality health insurance across age, income, geography and race/ethnicity. Furthermore, the impact of health insurance plans with tobacco use surcharges

## 3 THINGS TO KNOW

1

The American Heart Association does not proactively support tobacco surcharges and will advocate that if they are implemented, consumer protections must be in place that include access to free, comprehensive tobacco cessation services.

2

Without appropriate consumer protections in place, tobacco surcharges can reduce equitable access to affordable, quality health insurance across age, income, geography, and race/ethnicity.

3

Evidence for efficacy of inducements remains limited with some evidence that these may increase tobacco cessation.

*“The American Heart Association maintains that if health plans use tobacco surcharges, then consumer protections must be integrated that prevent these surcharges from becoming overly coercive or reduce access to equitable, affordable, health care by making health insurance too costly.”*

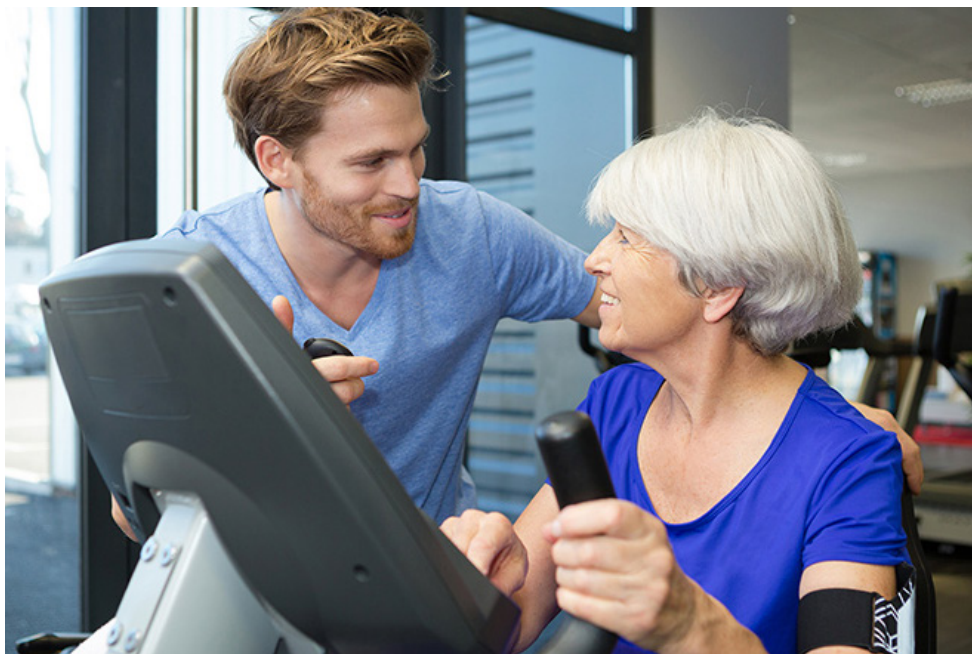
appears to be primarily related to disparate affordability between smokers and non-smokers, as well as decreased affordability with aging and in rural areas. Lastly, the review found that non-compliance with all parts of ACA has impacted access to smoking cessation programs in the small-group market, though compliance seems to be improving. Based on the updated review, the American Heart Association's position remains relatively unchanged.





# SUPERVISED EXERCISE TRAINING FOR CHRONIC HEART FAILURE WITH PRESERVED EJECTION FRACTION:

## A SCIENTIFIC STATEMENT FROM THE AMERICAN HEART ASSOCIATION (AHA) AND AMERICAN COLLEGE OF CARDIOLOGY (ACC)



living that reduces cardiac risk factors, e.g., smoking cessation, blood-pressure control, nutrition, and stress reduction. While the literature supports SET, CMS determined that the evidence on the benefits of these interventions is well established and thus chose to cover cardiac rehabilitation for HFrEF. The NCD request also asks CMS to update its definition of HFrEF to an ejection fraction (EF) of 40% or less in line with the updated definition (published in a 2021 paper “Universal Definition and Classification of Heart Failure”) and the substantial evidence of benefit of SET in HFrEF patients with an EF <40%.

Approximately half of all patients with heart failure (or three million Americans) have heart failure with preserved ejection fraction (HFpEF). Unfortunately, compared to the guideline-based care of patients with chronic heart failure with reduced ejection fraction (HFrEF), there are far fewer guideline-based medications and devices shown to be useful in treating HFpEF. Yet one constant in treatment guidelines for both HFrEF and HFpEF is supervised exercise training (SET).

Recent studies on the benefits of SET in HFpEF warranted the development of AHA and ACC’s scientific statement which was also endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), the American Association of Heart Failure Nurses (AAHFN), and the Heart Failure Society of America (HFSA). The statement outlines the research on SET in HFpEF and concludes that “in multiple (randomized clinical trials) of SET in selected patients with chronic, stable HFpEF, exercise is safe and provides substantial, clinically relevant improvements in aerobic exercise capacity and quality of life.”

The scientific statement was the basis for our request to the Centers for Medicare and Medicaid Services (CMS) that Medicare cover cardiac rehabilitation in HFpEF as it has for HFrEF since 2014 after AHA, AACVPR, ACC, and HFSA requested a national coverage determination (NCD) on cardiac rehabilitation in heart failure. Cardiac rehabilitation is SET plus interventions on heart-healthy

## 3 THINGS TO KNOW

1

The prevalence of HFpEF is increasing relative to HFrEF as our population ages and as comorbidities that contribute to the diagnosis (e.g., diabetes) become more common.

2

For people with HFpEF, SET is the only therapy shown to regularly improve health-related quality of life and exercise tolerance and to lessen early onset fatigue, a chief complaint in HFpEF.

3

Five organizations joined AHA in signing on to the NCD request to CMS: AACVPR, AAHFN, ACC, Association of Black Cardiologists, and HFSA.



Cite

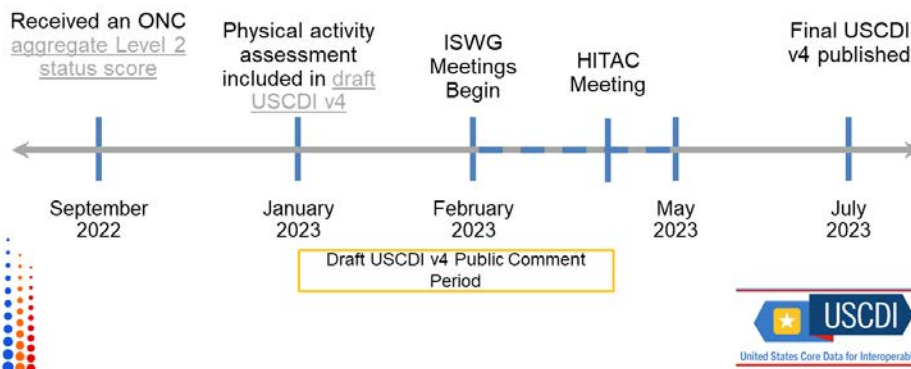


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# PHYSICAL ACTIVITY ASSESSMENT INCLUDED IN US CORE DATA FOR INTEROPERABILITY (VERSION 4)

## Physical Activity Status in the USCDI



The United States Data for Interoperability (USCDI) is the standard established by the Office of the National Coordinator (ONC) in the 2020 21st Century Cures Act Final Rule. It comprises a core set of data that supports patient care and promotes patient access using health information technology (HIT); and can be reused across HIT platforms (outside of patient care and patient access). It is updated on an annual basis with federal agency and industry input. Conforming to the USCDI is required

for certification in the ONC HIT Certification Program (currently this is USCDI version 1). Inclusion of the Physical Activity Assessment into the USCDI is an important goal of the **It's Time to Move** initiative.

In September 2022, representatives from the ONC encouraged the Physical Activity Alliance and the American Heart Association to apply to include Physical Activity Assessment (the determination of minutes per week of moderate to vigorous physical activity and the number of days per week of muscle strengthening exercise one is engaged) to the USCDI version 4. They felt that Physical Activity Assessment would be an important new data element that would result in measurable improvements in patient care and health. After two rounds

## 3 THINGS TO KNOW

1

According to the CDC, the peer-reviewed science that forms the basis of the Physical Activity Guidelines recommends a combination of activities (i.e., aerobic and muscle strengthening) for optimal health and thus, is important to monitor in the clinical setting. The physical activity elements of Physical Activity Assessment in the USCDI are necessary to measure whether people are meeting the guidelines.

2

Inclusion of the Physical Activity Assessment into USCDI will further solidify and standardize physical activity measures in electronic health records in the U.S., which could dramatically improve the health of the public and bring U.S. healthcare costs down.

3

The final USCDI version 4 was published in July 2023 and the review process for ONC's HIT Certification Program requirement will begin. It is anticipated that version 4 will be required in 2025.

*"At the local health level, having [Physical Activity Assessment] data will aid in creating community health assessments (i.e., chronic disease health assessments) and community health improvement plans."*  
– National Association of County and City Health Officials

of internal review, the application received a "Level 2" (most important) rating and recommended for inclusion in draft of USCDI version 4 released in January 2023. The draft was opened to public comment (through mid-April), and the application received all positive/supportive comments. The application was also reviewed by ONC's Implementation Standards Working Group, to which we were able to present and answer questions. This work group recommended Physical Activity Assessment to be included in the final version, which was subsequently approved by the Health Information Technology Advisory Committee (responsible for the final recommendations to ONC) in April. On July 20, 2023, the final v.4 was published and physical activity assessment was included.







# TELEHEALTH PRINCIPLES ADDENDUM



The COVID 19 Pandemic caused a radical shift in the telehealth landscape with the share of Medicare visits conducted through telehealth, increasing 63-fold, from

approximately 840,000 in 2019 to 52.7 million in 2020. There is no question that the public health emergency (PHE) has provided a real-world evidence opportunity to examine the efficacy, equity, and cost effectiveness of telehealth. Federal and state telehealth flexibilities affecting everything from coverage and reimbursement, service offerings, covered locations, eligible providers, equipment requirements, and

## 3 THINGS TO KNOW

1

Many of the telehealth flexibilities that were enacted for the Public Health Emergency (PHE) have been temporarily extended until 2024.

2

This extension allows investigators time to develop and carry out well-designed research, focused on answering questions raised by initial examination of data created by expanded practice during the PHE.

3

Existing health disparities not addressed by increased telehealth access have been made more pronounced and should be a priority for researchers and policymakers moving forward.

*“The AHA has developed key principles on telemedicine which guide our engagement at the state and federal levels, and we continue to support and monitor focused research to address policy and access gaps created by the end of the PHE.”*

HIPAA enforcement have provided health care researchers a trove of new data from which to learn and create a new foundation for evidence-based best practice and policy. This process, and the process of identifying and validating optimal quality metrics for evaluation, as well as translating evidence to policy, takes coordinated effort by academic institutions, government agencies, non-profit organizations, and associated organizations; and this coordination takes time. However, the American Heart Association continues to follow research outcomes closely and based upon the findings to date we present this update to our existing principles for telehealth.



# CANNABIS POLICY UPDATE

Marijuana, or cannabis, is the most commonly used federally-illegal 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. This policy guidance update provides some additional analysis in key public policy areas, including legalization, public health infrastructure, workplace safety and drug testing, retail density, the cannabis marketplace, criminal and social justice, Food and Drug Administration (FDA) regulation of drugs and food and nutritional supplements, youth use, drug testing for government assistance programs, school policy and expanding research at the federal and



## 3 THINGS TO KNOW

**1**

Legalization of marijuana for medical purposes should align with patient safety and efficacy and further research is needed to inform clinical practice guidelines. Legalization of marijuana for recreational use will remain a significant public health concern until there is more research on safety and long-term population health effect across the life course and we fully understand the equity and social justice impact of these laws.

**2**

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.

**3**

The increasing rate of adolescent and young adult use of cannabis in the US is alarming and has significant implications for mental and physical health outcomes across the lifespan.

state levels. It also summarizes the areas of intersection between marijuana and tobacco public policy.

Data from 2019 show that 48.2 million people, or about 18% of Americans used marijuana at least once that year and recent data indicate these numbers are continuing to rise. Gallup Survey data reveal that 49% of adults in the US have ever tried marijuana. Of significant concern, results from the National Survey on Drug Use and Health and the most recent Monitoring the Future Survey show concerning rates of adolescent and young adult cannabis use and indicate it is the second most used drug in the U.S., behind alcohol and ahead of tobacco and nicotine vaping.

Cannabis has significant deleterious effects on the brain and cardiovascular system, including some increased risk of developing depression, suicidal ideation, schizophrenia and other psychosis-related outcomes, and cardiovascular risks, including arrhythmias, myocardial infarction, and cardiomyopathy.

The cannabis market continues to grow across the country. Increasingly major tobacco companies are investing in and buying shares of cannabis and marijuana companies and diversifying their products to meet the needs of those who use marijuana. Tobacco companies are also lobbying for cannabis/marijuana at the state and federal levels. The density of retail outlets is growing exponentially across the country for both medical dispensaries and retail outlets for recreational access.





# VALUE-BASED PAYMENT FOR CLINICIANS TREATING CARDIOVASCULAR DISEASE:

## A POLICY STATEMENT FROM THE AMERICAN HEART ASSOCIATION



Despite spending significantly more on health care services per capita than any other country, the United States performs poorly on most population health outcomes compared to other developed countries. Cardiovascular disease has been and continues to be the leading cause of mortality, morbidity, and health disparities. Cardiovascular disease is also a significant driver of health care costs. Despite efforts by the American Heart Association (AHA) and others to address cardiovascular health through significant investments

and advancements over the years in science, medicine, and technology, cardiovascular health in this country continues to decline. Flawed health care payment (i.e., fee-for-service) and social policies are at the root of the issues that plague our health system.

To achieve the Institute for Healthcare Improvement's Triple Aim, which calls for improving experience of care; improving the health of populations; and reducing the per capita costs of care, significant changes to how care is delivered and paid for are needed. Health system transformation holds the potential for significant improvements to care delivery

and improved outcomes, which have not been realized under the current "system." While new care delivery and payment models have been around for over a decade, they are still in their nascent form.

This policy statement considers the current state of new care delivery and payment models, referred to in this paper as value-based payment (VBP) models, and makes recommendations for improvements to future model design including a central focus on health equity.

## 3 THINGS TO KNOW

1

United States health care costs are markedly higher than health care costs in other countries. In the traditional fee-for-service system, clinicians are paid based on the number of services provided, without financial incentive for quality or efficient resource utilization.

2

The goal of value-based payment (VBP) is to reward better outcomes, lower costs, or both, and, in doing so, encourages clinicians to improve the delivery of care. VBP programs should carefully weigh the incentives between lowering cost and improving quality of care and ensure an adequate focus on quality of care.

3

VBP program design must address equity in terms of reducing unintended consequences and by including equity measures in every program.



Cite



#AHAPolicy @AmHeartAdvocacy



# EMERGING POLICIES THAT PROMOTE EQUITABLE, SAFE MOBILITY

Physical activity is key to improving and maintaining cardiovascular health. Yet, a quarter of adults in the U.S. report being inactive, and rates among American Indian/Alaska Native, Black and Hispanic adults are even higher.

Active transportation, including walking, biking and rolling, can provide opportunities for physical activity. Adequate built environment infrastructure is critical for accessibility, connectivity to essential community destinations and safety. The American Heart Association (AHA) is committed to promoting evidence-based, equity-focused active transportation policies that improve pedestrian and bicyclist safety infrastructure and reach historically under-resourced communities.



Yet disparities persist. People in under-resourced communities continue to face persistent underinvestment in active transportation infrastructure and people in low-income areas have disproportionately higher rates of death while walking.

Innovative and grassroots-driven policies that promote equitable and safe mobility are emerging. While quantitative evidence supporting several of these policies is not yet available, the qualitative data and lived experiences of people in historically under-resourced communities or those facing structural racism have spurred implementation of some of these policies. As adoption continues, the AHA advocates for robust implementation and outcome evaluation to assess safety, health, economic, connectivity and active living impact.

This policy statement summarizes an environmental scan of emerging active transportation policies that may promote equitable, safe mobility. These policies include:

- Decriminalize mobility by repealing jaywalking and other walking and biking-related traffic violations;
- Lower speed limits to reduce the alarming rates of injury and death among pedestrians;

- Vision Zero policies embrace the safe systems approach to achieve zero traffic deaths;
- Vulnerable road user legislation seeks to establish penalties for injuring or killing vulnerable road users, though these are already established in many states.
- Safe Routes to School state coordinators can create stronger, more effective programs and new federal dollars are available to fund these positions.
- The enforceability and quality of active transportation policy implementation varies; polices that compel implementation may be needed.
- Parks can promote physical activity and community connectedness. Additional investment in parks, trails and greenway infrastructure, particularly in under-resourced communities, is needed.
- Transferring ownership of select state highways to local municipalities may allow for infrastructure improvements that facilitate safe active transportation.

## 3 THINGS TO KNOW

1

Physical activity is key to improving and maintaining cardiovascular health. Yet, a quarter of adults in the U.S. report being inactive.

2

Active transportation, including walking, biking and rolling, can provide opportunities for physical activity. Adequate built environment infrastructure is critical for accessibility, connectivity to essential community destinations and safety.

3

Innovative and grassroots-driven policies that promote equitable and safe mobility are emerging, including decriminalizing walking- and biking-related traffic laws, lowering speed limits, passing Vision Zero policies, investing in parks and trails infrastructure, and more.