American Heart Association and Nonprofit Advocacy: Past, Present, and Future
A Policy Recommendation From the American Heart Association

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Influencing public policy through advocacy is an essential strategy used by the American Heart Association/American Stroke Association (AHA/ASA) to achieve its health impact goals and programmatic objectives, which include helping all Americans lead healthier lives and reducing the incidence and consequences of cardiovascular disease and stroke. This advocacy work involves and engages the association’s national officers, researchers, volunteer advocates, staff, and the general public and is a core strategy and key work process of the AHA/ASA. The organization’s strategic approach to influencing public policy and leveraging its science and evidence base is not well known. This article provides the historical context of AHA advocacy, the organizational and legal structure under which these activities are carried out, the process used to develop the association’s public policy positions and goals, the approaches used to achieve these goals, and the methods that have been developed to evaluate progress. This statement also examines the various tools and tactics that advocacy organizations use to influence public policy and specifically how the AHA/ASA conducts policy research, legislative and regulatory lobbying, coalition building and grassroots mobilization, and media advocacy. Finally, the ways that AHA/ASA evaluates the impact of its advocacy efforts are discussed, highlighting specific case studies and a brief summary of the association’s 2010 to 2013 public policy agenda.

Historical Context

The AHA’s efforts to translate the science of cardiovascular disease and stroke into meaningful public policy began in earnest in the early 1980s. The association established a full-time office in Washington, DC, in early 1981 that was initially focused on increasing federal research funding administered by the National Institutes of Health. Other early policy priorities included tobacco control and support for programs that increased access to automated external defi-
brillators (AEDs), new clinical preventive benefits in the Medicare program, and nutrition policy.

The commitment and involvement of the AHA’s national volunteer officers contributed significantly to the success of these early advocacy initiatives. They helped establish and set an overall public policy legislative and regulatory agenda aligned with and complementary to the broader organizational priorities established by the AHA Board of Directors. Initially guided by the association’s medical professional volunteers, the role and contribution of lay leadership, patients, and community advocates grew exponentially, as did the impact and relevance for policymakers in the nation’s capitol and state legislatures throughout the country. As early as 1983, the University of Chicago’s National Health Policy Project identified the AHA as the 10th most influential nongovernmental organization and sixth most influential health association. Although the AHA trailed the well-established and better-funded American Medical Association and the American Hospital Association, it led almost 50 other comparable health organizations in influencing public policy.

Five years later, the AHA’s advocacy structure and federal lobbying network included 52 affiliates and encompassed more than 80% of all congressional districts. Many of these affiliates were also increasing their advocacy activity at the state level. Today, the association’s advocacy presence continues in Washington, DC, and includes efforts in all 50 states and Puerto Rico. Similarly, the association’s public policy agenda has grown, extending across a broad spectrum of issues from research and prevention to treatment and access to emergent cardiovascular and stroke care at the federal, state, and community levels.

Structure of AHA Advocacy

The AHA is a New York State–based nonprofit organization with its national headquarters (National Center) in Dallas, TX, and 7 organizational regions (affiliates) covering the entire country. Influencing public policy is one of several key work processes of strategic focus for the association. The National Center maintains an advocacy department to guide and direct the AHA/ASA’s overall public policy work and to manage the organization’s advocacy operations in the nation’s capitol. Each of the affiliates has the responsibility to resource, staff, and implement advocacy strategies and tactics directed to public policymakers at the state and local levels. The association’s vast array of lay and medical professional volunteers and donors supports the AHA/ASA’s advocacy efforts every year by making financial contributions, testifying before federal and state legislatures, writing comments to regulatory bodies, lobbying federal and state lawmakers, developing policy position statements, and engaging in grassroots and media advocacy activities.

At the National Center, AHA/ASA’s advocacy work is led by an executive vice president and a vice president for state advocacy and public health based in Dallas, TX, and a vice president for federal advocacy in Washington, DC. The National Center maintains a staff of more than 20 in Washington, DC, who are responsible for federal legislative and regulatory advocacy, media relations, policy research, grassroots mobilization, and federal agency relations. The National Center also maintains a staff to provide strategic guidance and technical assistance to affiliates and their advocacy operations.

At the affiliate level, state and local advocacy efforts are supervised by a vice president for advocacy with each state assigned at least 1 government relations director. Given the critical role that public policy and advocacy will continue to have to achieve the AHA’s new 2020 health impact goal, beginning in 2010, states with a population greater than 5 million will be encouraged to establish a second government relations director position. In these states, responsibilities will be divided between a health systems policy director and a prevention policy director (Figure 1), each responsible for relevant coalition development, legislative and regulatory lobbying, and gubernatorial and state agency relations. Currently, the AHA/ASA has 59 government relation directors, 11 grassroots directors, and 8 affiliate vice presidents of advocacy (Figure 2).

Legal Structure of AHA as a 501(c)3 Versus a 501(c)4 Organization

It is legally permissible, within limits, for a 501(c)3 public charity to promote and influence public policy. The limits placed on a 501(c)3 include the amount of organizational resources that are expended on these activities and an absolute prohibition on participating in any campaign activities. The Internal Revenue Service considers political campaign activity to be anything in which the reasonable consequences have the potential to influence voter opinion or to provide financial, volunteer, or other aid to benefit or defeat a candidate for public office. Examples of prohibited activities for a 501(c)3 include endorsements, public statements or advertisements for or against a candidate, campaign contributions, public distribution of candidates’ voting records, ratings of candidates, and voter guides on candidates during election campaigns, or issues of concern to the organization. A 501(c)3 organization may, however, conduct neutral or nonpartisan educational efforts without showing favoritism or bias to a candidate. Examples of these types of permissible activities include sponsoring a public forum or debate between candidates as long as it is structured in a neutral manner that favors no particular candidate. The AHA/ASA engaged in such allowed activities in 2000 and 2004 (Take Heart) and worked in conjunction with others in the 2008 election cycle to raise public and candidate awareness of healthcare reform as a key domestic policy priority (Are You Covered?) and the importance of funding for biomedical research (Your Congress/Your Health).

Other permissible activities include briefings or position papers directed to the public and/or to all candidates on topics of concern, educational outreach, petition drives if in support of legislation or a referendum, letter-writing campaigns setting out the organization’s position on issues related to its exempt purpose, and editorial board visits to educate the print or broadcast news media editors about legislation or public health issues. A 501(c)3 organization may also impartially and objectively inform its members how legislators voted. Finally, 501(c)3 organizations can conduct voter registration and get-out-the-vote drives.
To remain in compliance with the Internal Revenue Service’s advocacy expense limitations ("substantial part test"), the association’s advocacy, legal, and finance departments have established robust internal policies and processes to monitor and report organizational expenditures for lobbying and related reportable advocacy expenses in a uniform and consistent manner. AHA/ASA legal and advocacy staff meet periodically and at the end of the fiscal year to review these expenses and to identify issues, trends and potential future challenges to maintain association compliance with the substantial part test. The legal and advocacy teams also develop policies and procedures, prepare staff resources, and periodically conduct compliance training to educate and inform staff and volunteers of the full range of permissible and prohibited advocacy activities and requirements for reporting expenses. AHA/ASA government relations staff members in Washington, DC, are required to comply with all existing registration and reporting requirements. Similarly, affiliate government relations staff members in Washington, DC, are required to comply with all existing registration and reporting requirements. The legal and advocacy teams also develop policies and procedures, prepare staff resources, and periodically conduct compliance training to educate and inform staff and volunteers of the full range of permissible and prohibited advocacy activities and requirements for reporting expenses.

Some nonprofit organizations are legally structured as a 501(c)4 or have a separate affiliated organization that has 501(c)4 tax status. The 501(c)3 and 501(c)4 organizations are similar in that they are both not-for-profit organizations and their earnings may not benefit a private shareholder or individual. Both types of organizations are exempt from federal taxes, but state tax-exempt status varies. Donations to 501(c)4 organizations are not tax deductible unless they are public entities used for public services, whereas donations to 501(c)3 organizations are tax deductible. In contrast to a 501(c)3 organization, a 501(c)4 organization can engage in unlimited lobbying and participate in a political campaign, as long as it is consistent with the organization’s purpose and is not the organization’s primary activity.

As part of its fiduciary responsibilities, the AHA Board of Directors periodically reviews the advocacy activities of the association to determine whether the current legal structure and related restrictions are inhibiting its ability to achieve its mission, strategic goals, and public policy priorities. In 2009, the board reaffirmed its decision to maintain the association’s advocacy operations as a 501(c)3, noting that there are no immediate legal obstacles or barriers that would limit the AHA/ASA’s capacity to successfully influence public policy. Acknowledging that there could be circumstances that might compel the board to reevaluate this issue in the future in an expedited manner, it directed its legal counsel to be prepared to act on any future board action on this question.
Nonprofit organizations use a variety of strategies and tactics to influence public policy. Those with 501(c)4 tax status donate money to political campaigns to obtain access to and to influence elected officials. Often, these organizations develop political action committees to raise money for political candidates. Other groups gain influence through their ability to mobilize extensive numbers of constituents for or against particular issues or candidates. Organizations like the AHA/ASA, in large part, derive their influence through the science expertise and evidence-based policy that they can offer public officials.

Successfully influencing public policy is usually an incremental, long-term process, advancing in small steps and evolving over time. Although it is not always perceived or portrayed in this manner, lobbying is a fairly open, routine activity. Significant new policy initiatives usually take years to come to fruition because a robust and persistent effort is required to define issues; to gain the attention of policymakers, the media, and the public; and to achieve policy change. Successful nonprofit advocacy groups maintain a stable, persistent, focused presence on the same set of issues to which they devote the majority of their resources. Operating within a political environment fueled by exaggerated policy differences for the benefit of a 24-hour media cycle and a constant focus on securing a partisan gain, advocacy groups are constantly tempted to shift their attention from headline to headline issue or to focus only on “putting out fires.” The most successful groups tend to remain focused on their core issues, developing expertise, resources, and a strong reputation in specific areas. Maintaining advocacy operations in Washington, DC, and in state capitals provides a significant advantage for nonprofit organizations by strengthening their presence, enabling them to hone their lobbying expertise and to expand their advocacy capacity.

Perhaps the greatest asset of the AHA/ASA in public policy advocacy is the respect that the organization has cultivated over the years with officials at all levels of government. This respect emanates from the association’s steadfast commitment and ability to translate credible and robust science into public policy solutions, to provide credible experts from its grassroots network, and to make these experts available to the media. The scientific rigor that serves as the foundation for many of the AHA/ASA’s programs applies equally to the association’s federal, state, and local public policy advocacy initiatives. The AHA/ASA commits substantial resources to developing scientific statements, guidelines, policy statements, and original reports based on rigorous, peer-reviewed research, providing a trusted resource for the benefit of a 24-hour media cycle and a constant focus on securing a partisan gain, advocacy groups are constantly tempted to shift their attention from headline to headline issue or to focus only on “putting out fires.” The most successful groups tend to remain focused on their core issues, developing expertise, resources, and a strong reputation in specific areas. Maintaining advocacy operations in Washington, DC, and in state capitals provides a significant advantage for nonprofit organizations by strengthening their presence, enabling them to hone their lobbying expertise and to expand their advocacy capacity.

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for policymakers that reinforces the association’s credibility and creates a solid foundation for its advocacy positions. For legislators, their staff, the media, and government agencies, this expertise is essential because of the increasing complexity of many public health issues. Organizations that base their advocacy on credible, robust science quickly become the “go to” organization for their particular issues.

The association’s reliance on evidence-based policy also imposes limitations, sometimes preventing it from adopting policy positions in emerging areas for which science is lacking. As a result, the AHA/ASA periodically refrains from taking an absolute position on an issue or joining early coalition efforts. Although it is recognized that the lack of an AHA/ASA endorsement of new, innovative, and untested policy solutions can sometimes frustrate its public health advocacy partners, the strength of the association’s endorsement for proven policy interventions can serve as a catalyst for policy change. Sometimes, the AHA/ASA will endorse pilot initiatives (often at the local and state levels where emerging policy approaches develop first) to gather more evidence of impact or efficacy. This cautious approach has been essential in maintaining the association’s credibility, which it is diligent not to sacrifice for an “issue of the day,” despite consequences such as forgone short-term media attention or policymaker interest. The AHA/ASA balances the need for relevance in emerging public policy with the importance of moving forward with adequate evidence.

A recent study identified several common characteristics of successful nonprofit advocacy organizations recognized by policymakers and their staff, and the AHA incorporates many of these best practices. First, successful organizations hire their staff from government positions (often Congressional/state legislative offices) because this brings government experience, established personal relationships with government staff, and an understanding of the legislative process. Second, effective organizations take every opportunity to bring their grassroots volunteers and experts into direct contact with policymakers through personal visits, phone calls, testimony at hearings, Congressional or state capitol briefings or events, and appointments to expert advisory committees. Third, organizations provide expertise, offer information specific to the legislation, and are able to explain in nontechnical language how a bill would affect the legislators’ constituents, the economy, social equity, public opinion, the quality and effectiveness of any proposed program, and the reasons for supporting or opposing a piece of legislation. Finally, the most successful organizations focus priorities and resources on a few core issues.

The AHA’s Process for Developing Its Strategic Plan and Policy Agenda

The AHA’s national Advocacy Coordinating Committee, one of the key committees of the association’s national board, is responsible for establishing AHA policy positions, public policy agenda, and annual legislative and regulatory priorities. Every 3 years, the AHA undertakes a rigorous process to develop its strategic policy agenda and to provide an overarching document that gives the association’s federal, state, and local advocacy staff strategic guidance and direction on policy issues and positions that align with and support the AHA’s research, mission, and strategic priorities. A draft document is written by staff and reviewed by the association’s scientific councils, key volunteers, administrative cabinet, and AHA leadership and then finally reviewed and approved by the Advocacy Coordinating Committee and the national Board of Directors.

An abbreviated policy agenda and set of state and federal priorities are created annually from the 3-year strategic plan to maximize opportunities in each legislative session. The AHA considers various factors in establishing these annual state and federal priorities, including the political landscape and emerging versus mature policy issues, identifying those with the greatest potential for health impact and likelihood of success. For example, at the federal level, major legislative initiatives such as healthcare reform, child nutrition and transportation reauthorization, and other “must pass” bills can provide vehicles for AHA’s legislative priorities.

Six criteria recently affirmed by the Advocacy Coordinating Committee for evaluating new issues and advocacy opportunities include the following:

1. Does this policy or regulatory opportunity clearly align with AHA’s strategic plan and priorities?
2. Does the AHA/ASA have sound science and/or a position statement to guide advocacy efforts to make progress toward or to achieve the desired positioning or policy outcome that will have a meaningful impact?
3. Does the internal political will and organizational commitment exist to pursue the opportunity (eg, volunteer leadership support, business unit buy-in, dedication of advocacy resources necessary)?
4. Is there a reasonable likelihood of success (ie, current relevance of the issue, an established definition of success, acceptable timeframe, receptivity of decision makers)?
5. Will AHA/ASA involvement make any appreciable difference (policy outcome, AHA positioning and visibility, unique contribution)?
6. Are the risks acceptable? What are the consequences of failure, the impact on image/positioning, the effect of association with the issue and/or coalitions, and unintended consequences on patients/relationships?

There is also a rigorous process at the national level to develop state and local advocacy priorities that are measurable and achievable. The AHA/ASA considers intended outcomes and unintended consequences of its advocacy activities. The national state advocacy staff convenes issue teams comprising National Center and field staff members each spring to identify policy priorities and goals for the following year that are used to assess and measure accomplishments by state advocacy staff. These state and local advocacy goals and priorities are shared with AHA internal leadership teams and key volunteers and are submitted to the national Advocacy Coordinating Committee for approval. Once approved, guidance documents are prepared for state advocacy staffs and integrated into their annual performance evaluations.

Thus, the resulting public policy agenda and annual priorities are a product of a rigorous internal process that is based
on science, guided by the AHA’s health impact goals and strategic plan, and informed by the expert advice and counsel of AHA/ASA staff and volunteers.

Implementing the AHA’s Strategic Plan and Public Policy Agenda

The AHA/ASA works across the public policy continuum (Figure 3) to influence policy, including planning, stakeholder and coalition development, policy research and analysis, a comprehensive legislative and regulatory agenda, the creation of media advocacy and grassroots strategies, implementing policy change, and then following through with effective evaluation to assess implementation and the ultimate impact of the law or regulation. The AHA/ASA differs from many advocacy organizations in its focus on cardiovascular and stroke patients and its service to the general public as a voluntary health association, not a trade association representing dues-paying members. The AHA/ASA has state, national, and international influence that is relatively unique among patient advocacy groups. Whereas many organizations organize both their state and federal advocacy from a national office, the AHA/ASA has state advocacy staffs across the country and federal staff in Washington, DC. There is exceptional congruence between the association’s state and federal advocacy efforts with complementary policy agendas, collaborative policy research, shared best practices, cultivation of grassroots volunteers, identification of key contacts, and the use of researchers, healthcare professionals, and key volunteers to provide expertise and testimony.

There are specific roles for state and federal advocacy. Often, states are “laboratories” for policy development that inform federal advocacy and further state policy. Sometimes, states extend or strengthen federal-level policy. Certain issues are best addressed at the federal level where there is the need to develop national or cross-cutting solutions, and other issues are more appropriately addressed at the state or local level.

The AHA/ASA’s cause and public education campaigns often complement and help promote advocacy activities. For example, the Go Red for Women Campaign, which raises awareness of heart disease in women, helped build support for the Heart for Women legislation. Power to End Stroke, an education and awareness campaign that embraces and celebrates the culture, energy, creativity, and lifestyle of Americans, helps reinforce advocacy efforts to develop effective stroke systems of care. At the same time, the AHA/ASA’s advocacy work raises public awareness and can help build momentum that inspires people to look for information or to participate in programming that improves their health. These people can then become passionate advocates and put their new knowledge into action.

Often, the most effective nonprofit advocacy organizations shape their consumer messaging in a way that supports public consensus because it is extremely difficult, resource intensive, and typically beyond the means of even large nonprofits to change public opinion to support a policy goal.4 Tobacco policy is an exception. Countermarketing campaigns by public health organizations, publication of the Surgeon Gen-

Figure 3. American Heart Association (AHA) public policy continuum.
eral’s report, and scientific evidence around the health impact of tobacco smoke gradually transformed public opinion, making it socially unacceptable to smoke for many. A grassroots movement empowered the public health community to pursue fundamental policy change. Grassroots campaigns, even if they are at first unsuccessful, are powerful initiatives that increase awareness of a health issue, build community readiness for policy change, and can lead to healthier social norms. These were efforts beyond the means of one organization. The transformation in public opinion created the opportunity for successful policy change, including passage of smoke-free indoor air laws, tobacco taxation, the regulation of tobacco products, and tobacco cessation and prevention programs.

Policy Research: Creating the Foundation for AHA Advocacy

The role of policy research is to translate science into policy that provides a foundation for legislative and regulatory advocacy activities. The AHA’s policy research staff analyzes data, the scientific literature, and other health research that impacts legislative, regulatory, and other public policies affecting heart disease and stroke treatment and prevention. The policy research team coordinates scientific consensus and rigorous peer review to develop policy position statements, fact sheets, model legislation, and peer-reviewed publications to guide and support AHA/ASA advocacy. These products concisely summarize the relevant science, convey urgent policy problems, and outline courses of action and solutions. Policy statements are analytical, using facts and research to evaluate policies, to develop outstanding research questions, and to provide evidence for policy recommendations and programs. There are regular communication and integration between the AHA/ASA’s science and advocacy departments to identify, translate, and leverage relevant scientific statements into policy and to ensure that the policy recommendations included in scientific statements are based on the latest policy research.

The policy research staff monitors trends in health policy to identify emerging issues relevant to cardiovascular health and stroke. The staff also regularly evaluates state and federal legislation to determine whether it conforms to AHA/ASA policy positions and science; the staff also works with regulatory staff to help develop public comments to regulatory agencies.

Legislative and Regulatory Lobbying

The AHA’s legislative lobbyists at both the state and federal levels possess expertise on the legislative and regulatory process, develop close working relationships with public officials and their staffs, and are able to devise strategies to implement the policies and priorities adopted by the AHA Board of Directors. The AHA’s government relations efforts can be classified into 5 main sets of activities: (1) proactive legislative initiatives, (2) participation in coalitions, (3) support for other groups and coalitions; (4) provision of regulatory comments, and (5) placement of key AHA volunteers on government advisory groups and commissions.

The AHA/ASA is involved with numerous coalitions at the state and federal levels. Coalition and partner development provides the opportunity to work across sectors with many stakeholders to create policy efforts that are more effective, relevant, sustainable, and efficient compared with what could be achieved by a single organization.5–7 Coalitions can be established to achieve a short-term objective or to address a broad set of issues over a longer period of time. Accordingly, they can be formally structured with bylaws, defined roles, and a defined mission statement, or they can be ad hoc and more loosely structured. Some coalitions require financial or in-kind contributions to participate, but others do not. Coalitions capitalize on strength in numbers and the resources and capacity that each member brings to the group, including expertise, staff resources, legislative contacts, funding, and the opportunity to share work. Coalitions can foster new alliances, collaboration, and strategic working relationships. Regular communication, clearly defined roles, and consensus on the mission are essential for a well-functioning coalition or partnership. A united front of a coalition with multiple sectors working together to achieve a common purpose is often necessary to impress policymakers, the news media, and the public.

It is not, however, always beneficial or practical to work in coalitions. Potential partners may have difficulty reaching consensus without difficult compromises. The need for approval from each organization can often delay or prolong the advocacy initiatives. There may be differences with regard to goals, strategy, division of workload, or direction. Coalition activities need to remain focused on the group, not individual members, so organizations can lose ownership of an issue or recognition for their work. The AHA/ASA is strategic about choosing when it is optimal to participate in coalitions and partnerships and when it is more appropriate to move forward independently. The AHA/ASA has different roles within coalitions, sometimes leading and offering significant resources, and other times providing more tacit support, endorsement, and/or capacity-building.

Commercial interests that may oppose AHA/ASA health policy goals may use third parties and coalitions to advance their own policy agenda. For example, in tobacco advocacy, industry interest groups identified several groups as allies in opposing excise tax increases. Industry provided financial and logistical support to a labor management group, which served as a public relations “front” to distance tobacco companies from their positions.8 Industry is currently backing similar coalitions and partnerships to oppose beverage taxes such as New Yorkers Against Unfair Taxes and Americans Against Food Taxes. These coalitions are designed to seem as though they are consumer driven, but they are actually funded and resourced by the respective industry or manufacturer groups with a substantial economic interest in the topic.

Regulatory Activities

Regulatory advocacy is the process of influencing the executive branch and its agencies. Administrative agencies play a vital but less visible role in the policymaking process. Although many believe the chance to influence public policy ends when legislation becomes law, the regulatory process provides a continuing opportunity to influence how a law is implemented and enforced. Because laws and report language
are not always specific, state and federal agencies can have a great deal of discretion in implementing legislation. This allows the executive branch and its agencies to heavily influence the resulting public policy.

The AHA/ASA closely monitors federal and state agencies to identify opportunities to influence the regulatory process. For example, agencies routinely solicit public feedback as they develop regulations to implement a law, update existing regulations, work on past mandates, and issue guidelines or guidance documents. The AHA/ASA frequently responds to these requests for information by submitting written comments or providing oral testimony at agency meetings. The AHA/ASA shares its expertise with the agencies through meetings between AHA/ASA and agency staff and encourages the agencies to view the AHA/ASA as a resource and partner. Additionally, the AHA/ASA alerts agencies to experts in the community who can help address a specific issue; this may include nominating AHA/ASA volunteers for appointments to federal and state advisory committees.

Grassroots Advocacy: You’re the Cure
AHA/ASA advocacy activities focus on initiating and supporting policy changes that will improve the cardiovascular and brain health of Americans. A key to achieving these policy changes is connecting constituents with their policymakers. The You’re the Cure network comprises advocates committed to using their voices as constituents to influence policymakers and to build support for policies important to the AHA/ASA.

The AHA/ASA strives to recruit, engage, and mobilize You’re the Cure advocates across the country to influence heart- and stroke-related policy issues. The network, made up of nearly 200,000 advocates, reflects a diverse group of people who care about heart and stroke issues, including survivors, caregivers, researchers, medical professionals, and families. The You’re the Cure program seeks to continually increase the size of the network and to give constituents a voice in the political process. By providing a meaningful role for advocates, the AHA/ASA is building a strong volunteer relationship that can be leveraged for other programs and initiatives.

Advocates engage in various activities to influence their policymakers. At the simplest level, advocates send e-mails to their representatives about legislation that the AHA/ASA is supporting. Advocates take an active role above and beyond sharing those simple messages when they telephone their lawmakers, schedule in-person visits, participate in state and national Lobby Days, provide testimony, serve as media spokespersons, recruit other advocates, and share their stories.

It is important to build strong, long-lasting relationships with selected legislators (chosen for their influence and positions on key committees) that can be further strengthened through constituent contacts. Relationships with a few influential members on key committees can have far more impact than many superficial contacts. There is, however, an important role for general advocacy appeals that call on grassroots networks to write letters and to visit their legislative representatives at home. However, these more general appeals to “contact your representative” have to be made strategically or they easily can be discarded by busy legislative staff, especially if the number of e-mails or phone calls is not substantial.

Legislators take their cues from many different sources when determining their positions on specific legislation. Direct contact with a constituent can have a major impact, particularly when the legislator can identify with the concern. Hearing from a passionate constituent with a meaningful, memorable story can be the difference between a “yes” and a “no” vote, and the Grassroots Advocacy Department continually attempts to connect voters with their representatives through multiple avenues. In the end, often the best story wins. The one that means the most to the greatest number of people is the one that is remembered by lawmakers.

Media Advocacy and Its Role in Shaping Policy
The media is an important player in framing public policy debates, and media advocacy is another way of winning the necessary support for the AHA/ASA’s policy priorities. Media advocacy aims to use mass media for advancing a social or public policy initiative. Unlike public education or social marketing campaigns, which use the media to persuade an audience to change individual health behaviors, media advocacy works to develop news stories to build support for public policies or other issues. Media coverage is one of the best ways to gain the attention of decision makers, from local elected officials to members of Congress. Legislators take their cues from what they see in the morning newspapers (print or electronic) and on television news. They know the important role the media plays in shaping public opinion. Much of media advocacy is taking advantage of opportunities to advance the organization’s policy agenda and working closely with government relations, grassroots, policy research, and regulatory staff to integrate media advocacy in a public policy campaign. Often, the approach taken in a media advocacy plan is similar to that of a political campaign in which the association mobilizes a base of support for its issue and targets its messages to groups that can help attain a policy goal.

Measuring Success
The AHA assesses its progress and success by developing specific annual goals for state and federal advocacy with several metrics. These include tracking grassroots network engagement, media impressions, coalition work, letters of endorsement, advocacy events that build support for the AHA’s advocacy priorities, cosponsorships on legislation, regulatory comments submitted, policy articles and statements published, and lobbying activity. It is important not only to measure internal progress toward strategic policy goals but also to ensure that if legislation is passed or a regulation is established, there is timely and effective implementation and it fulfills its purpose. By assessing the impact and implementation of policy change, the association can determine whether its efforts are having a positive impact, there is need to follow up with additional legislation or regulation, or there were any unintended consequences or costs that need to be addressed. One example is local wellness policies that were adopted in the 2004 Child Nutrition and Women Infants and Children reauthorization. The legislation
required school districts to establish wellness councils and to
develop local wellness policies that incorporated nutrition,
nutrition education, and physical activity for the school
environment. The AHA/ASA analyzed how these policies
were implemented and concluded that implementation could
be improved with greater transparency, more accountability,
and more comprehensive policy development. Accordingly,
the AHA/ASA worked with its partners to create draft
language for the 2010 reauthorization of Child Nutrition to
improve and strengthen local wellness policies. If passed,
these changes would enhance the development of healthy
school environments.

Other organizations are realizing the impact of policy
evaluation and assessment. The Robert Wood Johnson Foun-
dation and The Pew Charitable Trusts recently established a
project to document the increasing use of health impact
assessments across the country. Health impact assessments
allow the collection of data to identify the health benefits and
consequences of new policies; they offer a tool to develop
practical strategies to minimize any adverse effects of policy
change and ensure the best possible health outcomes.9 The
health impact assessments foster the consideration of health
needs in policy and program decisions even in sectors that do
not traditionally focus on health outcomes. Grant makers are
encouraging the use of these tools as they provide funding to
ensure optimal impact of policy change in the area of public
health.

**Examples of AHA’s Advocacy Work**

The conceptual framework for much of the AHA/ASA’s
policy work is the social-ecological model that maintains that
an individual’s behavior is influenced by his or her surround-
ing physical, social, and cultural environments (see Figure
4).12 Policy has the greatest impact when it optimizes the
environments in which people live, work, learn, and play,
making healthier behaviors and healthier choices the norm,
putting individual behavior in the context of multiple-level
influences. Population-based strategies are a critical comple-
ment to preventive services and treatment programs in which
practitioners and patients work together to foster important
individual behavior and lifestyle changes.13

**Tobacco Control**

Advocacy around smoking cessation and prevention has been
an AHA/ASA priority for several decades. This policy work
is a remarkable example of the impact that advocacy can have
on reducing cardiovascular disease and stroke in the United
States. It also is an example of the patience required for
policy initiatives, the importance of a sound scientific evi-
dence base, the unique roles of state and federal advocacy, the
significance of working in a strong coalition, and the need to
minimize preemption so that states and localities can be
creative and innovative in their approaches to change public
perception and improve health. Smoke-free indoor air laws,
tobacco excise taxes, tobacco cessation and prevention pro-
grams, and regulation of tobacco are the primary means of
achieving the public health impact.

The AHA advocates for comprehensive smoke-free work-
place laws at the state and local levels, in compliance with the
Fundamentals of Smoke-Free Workplace Laws guidelines.14
These guidelines and fundamental principles were developed
with several national partners in the public health community
to guide and maximize the impact of smoke-free policy
efforts and to increase the number of workers and residents in
the United States who are protected from secondhand smoke
in workplaces and public places. The principles incorporate
experiences and lessons learned from tobacco control adva-
cates across the country over the past several decades. Some
of these principles include sufficient planning, emphasis on
local initiatives, resource allocation, strong grassroots orga-
nization, community readiness, model policy language, and
the need to use expert advisors. In the case of smoke-free air
policy, the AHA discouraged federal clean indoor air laws and
focused its efforts on local and state advocacy so that munici-
palities could pass robust laws, create momentum around the
country, and change public perception over time. By focusing at
the state and local levels, the AHA and its public health partners
forced the powerful, well-financed tobacco industry to spread its
resources around the country, rather than concentrate them to oppose one piece of federal legislation.

The impact of advocacy around smoke-free air is becoming clear. Experimental and epidemiological studies support a causal relationship between smoking bans and decreases in acute coronary events. Studies from around the world provide evidence for a reduction in hospital admissions for acute myocardial infarction after implementation of smoke-free indoor air laws. According to the American Non-Smokers Rights Foundation, at the end of 2009, a total of 30 states, in addition to Puerto Rico and the District of Columbia, had laws requiring 100% smoke-free workplaces and/or restaurants and/or bars (see http://www.no-smoke.org/goingsmokefree.php?id=519 for updated statistics as new laws and regulations are passed).

The AHA will continue to work on this issue until the entire country is covered by robust, smoke-free air laws.

National guidance and resources are often implemented by states and localities. An example is the Centers for Disease Control and Prevention’s best practice guidelines for tobacco cessation and prevention that have been implemented by many states and localities as part of comprehensive tobacco control programs.

Additionally, tobacco advocacy provides an example of the importance of working in a strong coalition, in this case, the Campaign for Tobacco Free Kids. This campaign is the nation’s largest nongovernmental initiative ever launched to protect children from tobacco addiction and exposure to secondhand tobacco smoke. The campaign supports tobacco policy efforts at the local, state, federal, and global levels. The AHA, as a leading member of the coalition, along with the American Cancer Society and the American Lung Association, pays dues to support the work of the campaign staff. The campaign has provided tremendous expertise and capacity for tobacco policy in the United States.

The federal role in tobacco advocacy is most apparent with US Food and Drug Administration regulation of tobacco. In a historic and long-fought victory, in June 2009, Congress and the President gave the Food and Drug Administration the authority to regulate the manufacturing, marketing, and sale of tobacco products. This new law was the result of decades of advocacy by the AHA and numerous public health partners and ended the special protection from regulation that the tobacco industry enjoyed for so long. The AHA and its partners will monitor implementation of the law to ensure that it has its intended impact on the public health of the nation.

Tobacco excise taxes are an example of a combined state and federal approach. The federal government has imposed excise taxes, most recently with the expansion of the Children’s Health Insurance Program. A cigarette tax increase of 61.66 cents per pack went into effect on April 1, 2009. There were also increases in the federal tax rates on other tobacco products such as smokeless products, “small cigars,” roll-your-own tobacco, and regular cigars.

At the same time, states have imposed tobacco excise taxes with a current nationwide average of $1.45 per pack (as of July 2010). As a highlight, the state of New York (June 2010) raised its cigarette tax by $1.60 to give it the highest cigarette tax in the nation at $4.35 per pack. The AHA/ASA continues to advocate at both the state and federal levels for robust tobacco excise taxes because evidence shows that for every 10-cent increase in tobacco taxes, cigarette consumption declines by 7%.

Efforts by the AHA have contributed to a decline in US cigarette consumption by more than 24% over the last decade. Despite this progress, 23.1% of men and 18.3% of women in the United States still smoke. As long as this is the case, tobacco control advocacy will remain a key priority for the AHA/ASA.

AED Placement/Cardiopulmonary Resuscitation Training and Good Samaritan Laws

Over the years, the AHA has given priority to cardiopulmonary resuscitation training for the US population and the placement of AEDs in public places (such as airports and government buildings) to ensure optimal response when a person experiences sudden cardiac arrest. Cardiopulmonary resuscitation training and use of an AED are essential elements in the chain of survival in the emergency response to a cardiac arrest. When the AHA first tried to implement its cardiopulmonary resuscitation and public access to defibrillation programs, one barrier was concern over civil liability (ie, a layperson who tried to use an AED or administer cardiopulmonary resuscitation or the company that established the program might be subject to liability if the patient was hurt or did not survive). The AHA then advocated for Good Samaritan Laws to remove this perceived barrier and to protect both the individuals coming to the aid of a person in cardiac arrest and those companies that established programs. These laws increased the impact of AHA’s training programs by reducing bystanders’ hesitation to assist in emergency situations and provided support to companies and others that established public access to defibrillation programs. Every state now has some form of Good Samaritan Law, and 40 states have lay rescuer protections and 26 states have program facilitator protections that meet AHA recommendations. This is an excellent example of AHA advocacy efforts helping to overcome a barrier to program implementation.

Nutrition Standards in Schools

Working with the William J. Clinton Foundation, the AHA established the Alliance for a Healthier Generation, an initiative to address childhood obesity and to reverse the nation’s adult obesity epidemic. In May 2006, the alliance announced a landmark agreement with the beverage industry to eliminate full-calorie beverages from schools across the nation and to promote lower-calorie, smaller-portion beverages to reduce the calories consumed by children in the school environment. In 2007, the AHA and the alliance established science-based snack food guidelines for competitive foods in schools to promote consumption of a healthy, balanced diet that is rich in whole grains, fruits, and vegetables, with limited intake of fats, salt, and calories. Subsequently, the Institute of Medicine published a report on nutrition standards in schools that some states wanted to use as the basis for legislation and/or regulation. Although there are some differences between the AHA’s competitive food and beverage standards and those of Institute of Medicine, the two are largely aligned because both are based on the best available science.
The Clinton alliance beverage agreement lasted for 3 years, with the program’s effectiveness reflected in independently prepared annual progress reports. The final assessment in 2010 showed the significant impact of this voluntary, landmark agreement: 88% fewer beverage calories were shipped to schools between 2004 (the last comprehensive data available before the agreement) and the end of 2009; shipments of full-calorie soft drinks to schools declined by 95% during that time; and 98.8% of schools and school districts measured were aligned with the guidelines. Beverage companies spent thousands of hours educating and training sales forces and invested millions of dollars in retrofitting vending machines, repackaging products, and reconfiguring production lines and equipment.

A recent report from the Centers for Disease Control and Prevention’s School Health Profiles Survey reiterated the substantial progress made across the United States in increasing the percentage of secondary schools in which students could purchase more nutritious snack foods and beverages outside the school meal program. The report showed that among the 34 states that collected data in 2006 and 2008, the median percentage of secondary schools that did not sell soda or fruit drinks (except those that are 100% juice) increased from 38% in 2006 to 63% in 2008. The median percentage of secondary schools that sold candy or snacks that are low in fat increased from 46% in 2006 to 64% in 2008. The greatest improvements occurred in states that adopted strong school nutrition standards and policies for foods and beverages outside school meal programs, reinforcing the importance of public policy change in changing an unhealthy environment.

Another recent report by the Robert Wood Johnson Foundation’s Bridging the Gap program found that there remains room for improvement in elementary schools in which soda and junk foods are still being offered. However, the findings were based on surveys of school administrators during the 2006 to 2007 and 2007 to 2008 school years and may not have accounted for the more recent developments in improving nutrition standards.

The effect of the alliance’s activities illustrates the importance of public policy efforts to extend voluntary agreements to make them more sustainable. There is some disagreement about the long-term effectiveness of voluntary agreements and the ability of industry to regulate itself. Legislative and regulatory advocacy can reinforce, complement, and sustain voluntary initiatives. For nutrition standards in schools, there have been multiple examples at the state and federal levels in which advocacy efforts are strengthening the voluntary agreement. The AHA has advocated for robust nutrition standards at the state level that align with the alliance criteria.

At the federal level, the 2004 Child Nutrition and Women Infants and Children Reauthorization Act required schools to establish local wellness policies that addressed nutrition standards. In the current reauthorization, the AHA is advocating that these wellness policies be strengthened with greater implementation, accountability, and assessment. If the current Child Nutrition Reauthorization language remains in its present form and becomes law, the US Department of Agriculture will for the first time have the authority to establish robust nutrition standards for foods and beverages sold in schools from vending machines, a la carte, in school stores, and outside the meal program. The legislation will also strengthen nutrition education and promotion and improve the quality of the US commodities provided to the school meal program.

Finally, grant-funding opportunities supported by the American Recovery and Reinvestment Act of 2009 provide major cities and states with the capacity through the Communities Putting Prevention to Work initiative to address nutrition policy, including strengthening nutrition and beverage standards in schools. All of these AHA-supported nutrition policy changes demonstrate the opportunity for advocacy to extend voluntary agreements by reinforcement through legislation or regulation, resulting in increased sustainability, accountability, and long-term impact.

### Physical Education in Schools/Fitness Integrated With Teaching Kids Act

Strengthening physical education has been an AHA/ASA priority for nearly a decade. Physically fit children are more likely to thrive academically and socially. Through effective physical education, children learn how to incorporate safe and healthy activities into their lives. Physical education is an integral part of developing the “whole” child in social settings and the learning environment. At the state level, the AHA/ASA advocates for daily, quality physical education (150 min/wk in elementary schools and 225 min/wk in middle and high school). The association supports policies that would:

- Require all school districts to develop and implement a planned kindergarten through 12th grade physical education curriculum that adheres to national and state standards
- Hire a physical education coordinator at the state level to provide resources and to offer support to school districts
- Offer regular professional development opportunities to physical education teachers that are specific to their field
- Require physical education teachers to be highly qualified and certified
- Add valid fitness, cognitive, and affective assessments in physical education that are based on student improvement and knowledge gain
- Encourage students to be active in moderate to vigorous physical activity for at least 50% of physical education class time
- Provide appropriate equipment and adequate facilities
- Require physical education for graduation
- Not allow students to opt out of physical education to prepare for other classes or standardized tests
- Not allow waivers or substitutions

Advocating on these issues has been challenging, given the pressures of limited time in the school curriculum, strained resources, and the emphasis on preparing for standardized tests. Even if laws are passed, they may not be fully implemented if schools do not have the resources to hire enough teachers and to maintain or build adequate facilities. The 2010 Shape of the Nation Report revealed that despite incremental improvements in making physical education a
requirement, an increasing number of states have allowed waivers and exemptions from physical education classes; no progress has been made in requiring daily physical education in all grades from kindergarten through 12th grade.26

At the federal level, there was significant pressure to insert physical education as part of the core curriculum requirements in the Elementary and Secondary Education: Improving America’s Schools Act (ESEA), which reauthorizes the federal act that provides funding for services to low-achieving students and a variety of other educational programs. The AHA did not feel it was able to navigate the contentious education debate as a public health organization. Working with congressional staff and an educational consultant, the advocacy team crafted legislation that holds schools accountable for providing students with high-quality physical education and activity every day. These provisions provide information that can help parents, Parent Teacher Organizations, and others shape approaches to increase physical activity among students based on available time and resources. The Fitness Integrated With Teaching (FIT Kids) Act provides information to parents and the public by requiring all schools, districts, and states to report on students’ physical education programs on school report cards already required under ESEA. FIT Kids also supports professional development for teachers and principals to promote children’s healthy lifestyles and physical activity and funds a study to examine the impact of health and physical activity on student achievement.

The AHA took the lead in finding congressional sponsors for the FIT Kids Act and used grassroots and media advocacy strategies to promote the bill in both the House of Representatives and Senate. Over the past 3 years, the AHA sponsored or participated in events on Capitol Hill with the National Football League, the National Association for Sport and Physical Education, and celebrities and developed a sophisticated and engaging grassroots campaign. Government relations staff also built a coalition of supporters for the bill that includes more than 70 organizations, provided witnesses for hearings on the legislation, and conducted numerous meetings with Capitol Hill staff to explain the legislation.

As of June 2010, FIT Kids had 111 cosponsors in the House of Representatives and 23 in the Senate. It enjoys widespread support among members on the relevant House and Senate committees. First Lady Michelle Obama began a complementary “Let’s Move” initiative to encourage physical activity and healthy eating habits among children. In response to momentum created by the Let’s Move campaign, the House passed a streamlined version of FIT Kids in April 2010. The AHA will continue to work to incorporate the more comprehensive language into any future authorization of ESEA or other opportunities that arise at the federal level.

The AHA’s work in physical education policy illustrates the need to tailor an advocacy strategy based on the potential contributions at each level of government; the value of a comprehensive and integrated strategy that includes policy, government relations, grassroots, and media advocacy components; and the need to assess the environment for opportunities

Table. AHA Strategic Policy Agenda 2010–2013

<table>
<thead>
<tr>
<th>AHA Strategic Priority</th>
<th>Advocacy Plan to Achieve this Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support heart disease and stroke research and the research environment</td>
<td>Provide support for basic, clinical, translational, health services, outcomes, genomics, and comparative effectiveness research and the overall research environment, as well as community health services, public health programs, policy evaluation and economics. Lift barriers that impede the conduct of medical research</td>
</tr>
<tr>
<td>Promote cardiovascular health</td>
<td>Promote public policies aimed at promoting and improving health for all Americans. Obesity prevention, diagnosis, and treatment; nutrition; physical activity/physical education; tobacco control; and prevention of air pollution</td>
</tr>
<tr>
<td>Support high-quality/high-value heart disease and stroke care and reduce health disparities</td>
<td>Promote public policies aimed at improving healthcare quality, reducing health disparities, and promoting high-value, evidence-based cardiovascular care. Improve healthcare quality. Promote safe, evidence-based, and high-value treatments for cardiovascular disease and stroke</td>
</tr>
<tr>
<td>Ensure appropriate and timely access to heart disease and stroke care</td>
<td>Advance comprehensive coverage and timely access to appropriate care for heart disease, peripheral artery disease, and stroke with a focus on adequate and affordable coverage, appropriate systems of emergency care, telemedicine, and surveillance</td>
</tr>
<tr>
<td>Healthcare reform and implementation</td>
<td>Systems of care</td>
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<tr>
<td></td>
<td>Stroke</td>
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<tr>
<td></td>
<td>STEMI</td>
</tr>
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<td></td>
<td>Out-of-hospitalcardiacarrest</td>
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<td></td>
<td>Telehealth</td>
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<td></td>
<td>Rehabilitation</td>
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<td></td>
<td>Other emergency care</td>
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<tr>
<td></td>
<td>Surveillance</td>
</tr>
<tr>
<td>Protect the nonprofit environment</td>
<td>Ensure the continued societal contributions and viability of nonprofit organizations by monitoring and, as appropriate, including legislative and regulatory efforts that attempt to restrict or prohibit charitable giving and other nonprofit efforts and activities</td>
</tr>
</tbody>
</table>

AHA indicates American Heart Association; STEMI, ST-elevation myocardial infarction.
to move provisions that achieve AHA strategies objectives in larger, “must pass” legislation. It also represents the patience and persistence required in advocating on an issue for a long period of time and conducting effective leadership on a signature issue for the association.

**Future AHA Advocacy: 2010 to 2013**

Recently, the AHA developed its strategic policy agenda for 2010 to 2013 with an emphasis on all of the critical areas that will help the association reach its 2020 goals of decreasing death and disability from cardiovascular disease and stroke and improving the cardiovascular health of the population (Table; the complete agenda can be found at http://www.heart.org/HEARTORG/Advocate/PolicyResources/Policy-Resources_UCM_001135_SubHomePage.jsp). These include strategies focusing on increased funding for heart disease and stroke research; promoting cardiovascular health through obesity, nutrition, physical activity, and clean air policies; and supporting high-quality/high-value heart disease and stroke care and timely access to heart disease and stroke care. Included in each of the strategic areas is the association’s commitment to proactively confront and address, through public policy, the health inequities and disparities that exist in the United States.

**Conclusion**

The AHA’s advocacy activities are of critical importance if the association is to achieve its 2020 goals to decrease death and disability from heart disease and stroke and to improve the cardiovascular health of all Americans. Public policy is a key component of transforming the public health. The association’s advocacy work fosters a well-grounded enthusiasm among the AHA’s staff and volunteers. This is reflected in the AHA’s passionate, engaged volunteers and supporters, legislative lobbying, regulatory activities, policy research, and media advocacy that extend across the country and affect every level of government. The scope of the AHA’s advocacy activities and particular tactics and strategies will evolve in response to the policy environment and to the needs of individuals who have heart disease and stroke. Ultimately, the AHA strives to transform the environments in which people live to promote health, to create quality health care, to improve medical treatment, to support robust scientific research, and to help people live longer, healthier lives, free of heart disease and stroke.

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**Appendix A. Stroke Advocacy**

**OVERALL STROKE SYSTEM COORDINATION**

Advocacy efforts at the federal level in support of increased funding for MEDICAL RESEARCH and for HEALTH CARE REFORM and at the state level to implement STROKE SYSTEMS OF CARE help address the needs of current and future stroke patients across the entire continuum of stroke care, from awareness and primary prevention to rehabilitation and recovery.

<table>
<thead>
<tr>
<th>Awareness &amp; Primary Prevention</th>
<th>EMS &amp; Pre-Hospital</th>
<th>Acute Care</th>
<th>Secondary Prevention</th>
<th>Rehab &amp; Recovery</th>
<th>Continuous Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improve public/private insurance coverage of clinical preventive services</td>
<td>• EMS transport protocols</td>
<td>• Removing barriers to telestroke</td>
<td>• Funding for CDC State Heart Disease &amp; Stroke Prevention</td>
<td>• Medicare therapy caps</td>
<td>• Add stroke quality measures to Medicare</td>
</tr>
<tr>
<td>• Public education campaigns</td>
<td>• Training for EMS personnel</td>
<td>• Reimbursement for tPA</td>
<td></td>
<td>• Private health insurance coverage for medically necessary therapy</td>
<td>• Support of Coverdell Stroke Registry, state registries</td>
</tr>
</tbody>
</table>

EMS indicates emergency medical services; tPA, tissue-type plasminogen activator; GWTG, Get With The Guidelines; CDC, Centers for Disease Control and Prevention.
### Appendix B. Policy Strategies to Achieve Ideal Cardiovascular Health

#### Measure of Cardiovascular Health

<table>
<thead>
<tr>
<th>Smoking status</th>
<th>Advocacy/Policy Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal for cardiovascular health:</td>
<td>Comprehensive clean indoor air laws</td>
</tr>
<tr>
<td>Adults: never smoked or quit &gt;1 y ago</td>
<td>Excise taxes on tobacco products</td>
</tr>
<tr>
<td>Children: never tried or never smoked a whole cigarette</td>
<td>Increase/sustain funding for state smoking cessation/prevention programs</td>
</tr>
<tr>
<td>Go to <a href="http://www.americanheart.org/tobaccontrol">www.americanheart.org/tobaccontrol</a> for additional policy resources</td>
<td>Comprehensive implementation of FDA regulation of tobacco</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical activity</th>
<th>Advocacy/Policy Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal for cardiovascular health:</td>
<td>Implement clinical guidance and monitor health claims around smokeless tobacco and other “harm reduction” products</td>
</tr>
<tr>
<td>Adults: ≥150 min of moderate or ≥75 min of vigorous physical activity each week.</td>
<td>Comprehensive smoking cessation benefits in Medicaid, Medicare, and other health plans</td>
</tr>
<tr>
<td>Children: &gt;60 min of moderate to vigorous physical activity a day.</td>
<td>Eliminate tobacco sales in pharmacies and other health-related institutions</td>
</tr>
<tr>
<td>Go to <a href="http://www.fitkidsact.org">www.fitkidsact.org</a>, <a href="http://www.americanheart.org/workplacewellness">www.americanheart.org/workplacewellness</a>, and <a href="http://www.americanheart.org/obesitypolicy">www.americanheart.org/obesitypolicy</a> for additional policy resources</td>
<td>Address the built environment and support efforts to design workplaces, communities, and schools around active living; integrate physical activity opportunities throughout the day</td>
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<td></td>
<td>Fund and develop walking/biking trails that connect key aspects of the community; increase safe routes to school; implement zoning/building ordinances that encourage walking/stair use, wider streets to allow for biking and walking, pedestrian-friendly streets and roadways with appropriate crosswalks, sidewalks, traffic lights, etc, and slower speed limits in walking/biking areas</td>
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<td></td>
<td>Implement shared use of school facilities within the community and support the construction of school fitness facilities</td>
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<td></td>
<td>Increase sports, recreational opportunities, parks, and green spaces in the community</td>
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<td></td>
<td>Increase the quantity and improve the quality of physical education in schools; support 60 minutes of supervised, moderate-vigorous physical activity per day integrated throughout the school day</td>
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<tr>
<td></td>
<td>Help implement the national physical activity plan;</td>
</tr>
<tr>
<td></td>
<td>Adequate prevention, diagnosis, and treatment of overweight and obesity in the healthcare environment</td>
</tr>
<tr>
<td></td>
<td>Robust surveillance and monitoring</td>
</tr>
<tr>
<td></td>
<td>Comprehensive worksite wellness programs</td>
</tr>
<tr>
<td></td>
<td>Implement and monitor strong local wellness policies in all schools.</td>
</tr>
<tr>
<td></td>
<td>Adequate funding and implementation of coordinated school health programs</td>
</tr>
<tr>
<td></td>
<td>Comprehensive obesity prevention strategies in early childhood and daycare programs;</td>
</tr>
<tr>
<td></td>
<td>Work to eliminate food deserts and to improve access and affordability of healthy foods</td>
</tr>
<tr>
<td></td>
<td>Strengthen nutrition standards in schools for meals and competitive foods and in all government nutrition assistance or feeding programs</td>
</tr>
<tr>
<td></td>
<td>Improve food labeling</td>
</tr>
<tr>
<td></td>
<td>Menu labeling in restaurants</td>
</tr>
<tr>
<td></td>
<td>Continue to monitor the removal of industrially produced trans fats from the food supply and ensure the use of healthy replacement oils</td>
</tr>
<tr>
<td></td>
<td>Address food marketing and advertising to children</td>
</tr>
<tr>
<td></td>
<td>Nutrition education/promotion in schools</td>
</tr>
<tr>
<td></td>
<td>Limit added sugar and sodium in the food supply</td>
</tr>
<tr>
<td></td>
<td>Ensure adequate healthcare coverage for prevention and treatment of dyslipidemia</td>
</tr>
<tr>
<td></td>
<td>Increase funding for programs that eliminate health disparities</td>
</tr>
</tbody>
</table>

#### Body mass index

<table>
<thead>
<tr>
<th>Ideal for cardiovascular health:</th>
<th>Advocacy/Policy Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults: Between 18.5 and 25 kg/m²</td>
<td>Adequate prevention, diagnosis, and treatment of overweight and obesity in the healthcare environment</td>
</tr>
<tr>
<td>Children: Between the 15th and 85th percentiles</td>
<td>Robust surveillance and monitoring</td>
</tr>
<tr>
<td>Go to <a href="http://www.americanheart.org/obesitypolicy">www.americanheart.org/obesitypolicy</a> for additional policy resources</td>
<td>Comprehensive worksite wellness programs</td>
</tr>
</tbody>
</table>

#### Healthy diet

<table>
<thead>
<tr>
<th>Ideal for cardiovascular health:</th>
<th>Advocacy/Policy Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults and children should achieve 4 of the 5 following key components of a healthy diet:</td>
<td>Work to eliminate food deserts and to improve access and affordability of healthy foods</td>
</tr>
<tr>
<td>Fruits and vegetables: &gt;4.5 cups a day</td>
<td>Strengthen nutrition standards in schools for meals and competitive foods and in all government nutrition assistance or feeding programs</td>
</tr>
<tr>
<td>Fish: 2 or more 3.5-oz servings a week (preferably oily fish)</td>
<td>Improve food labeling</td>
</tr>
<tr>
<td>Fiber-rich whole grains (&gt;1.1 g fiber per 10 g carbohydrates): three 1-oz-equivalent servings per day</td>
<td>Menu labeling in restaurants</td>
</tr>
<tr>
<td>Sodium: &lt;1500 mg/d</td>
<td>Continue to monitor the removal of industrially produced trans fats from the food supply and ensure the use of healthy replacement oils</td>
</tr>
<tr>
<td>Sugar-sweetened beverages: &lt;450 kcal (36 oz) per week</td>
<td>Address food marketing and advertising to children</td>
</tr>
<tr>
<td>Go to <a href="http://www.americanheart.org/obesitypolicy">www.americanheart.org/obesitypolicy</a> for more specific policy resources</td>
<td>Nutrition education/promotion in schools</td>
</tr>
</tbody>
</table>

#### Total cholesterol

<table>
<thead>
<tr>
<th>Ideal for cardiovascular health:</th>
<th>Advocacy/Policy Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults: &lt;200 mg/dL</td>
<td>Limit added sugar and sodium in the food supply</td>
</tr>
<tr>
<td>Children: &lt;170 mg/dL</td>
<td>Ensure adequate healthcare coverage for prevention and treatment of dyslipidemia</td>
</tr>
<tr>
<td></td>
<td>Increase funding for programs that eliminate health disparities</td>
</tr>
</tbody>
</table>

(Continued)
Appendix C

The American Heart Association: Addressing Health Disparities Through Advocacy

The AHA pursues a comprehensive advocacy agenda to address a range of issues in the areas of heart disease and stroke research, cardiovascular health (nutrition, physical activity, obesity treatment and prevention, tobacco cessation and prevention, and air pollution), the quality and value of heart disease and stroke care, and appropriate and timely access to care. Embedded throughout our advocacy work at the local, state, and federal levels is a commitment to confront proactively and to address, through public policy, the health inequities and disparities that exist in our country. In addition to prioritizing policy goals to serve diverse and disparate populations, AHA also works to engage these individuals in its grassroots advocacy campaigns. Recruitment materials reflect diverse populations; advocates engaged in grassroots and media advocacy opportunities represent a diverse audience; and outreach is conducted through cultural health initiatives to engage a diverse audience.

If the AHA is to achieve its 2020 goals to reduce death and disability resulting from cardiovascular disease and stroke by 20% and to improve the cardiovascular health of all Americans by 20%, the association has to prioritize opportunities to address social inequities, issues specific to vulnerable populations (ethnic and racial minorities, those with low income or less education, children, blue collar workers), and the importance of removing barriers and obstacles for risk reduction and behavior change. Often the most disadvantaged members of the population have the greatest need for preventive screenings, health promotion, or programming and have the least access to or are the most reluctant to participate in these opportunities. The fundamental causes of vulnerability are rooted in issues of daily life, most often beyond the scope of traditional public health, so it will be important for the AHA to consider engaging with nontraditional partners to consider ways to reduce health disparities in communities.

The following list is a summary of some of the specific ways AHA advocacy addresses issues around health disparities and vulnerable populations.

- Support delivery system reforms throughout the continuum of care aimed at improved care coordination (including disease management, transitional care, hospice, and end-of-life interventions), as well as initiatives aimed at supporting family caregivers of persons with cardiovascular disease and stroke.
- Support the development, implementation, evaluation, and dissemination of effective public health policies and programs to promote cardiovascular health and to reduce the burden, disparities, and costs of cardiovascular diseases.
- Work to eliminate race, sex, and geographic disparities in health care.
- Address the adequacy of the healthcare workforce to meet the needs of disparate populations in underserved areas.
- Promote reporting on healthcare quality measures, including by sex and ethnicity.
- Advocate for additional research to determine how best to reach and engage underserved populations and to optimize policy interventions for people of all races, age, ethnicities, educational attainment, and income levels.
- Support health plan coverage that includes essential healthcare services such as hospital and ambulatory care, prescription drugs, preventive services, emergency care, and rehabilitation.
- Eliminate financial barriers to preventive services in public and private health insurance plans.
- Ensure that personalized healthcare services are accessible to everyone.
- Remove barriers for rehabilitation and treatment of heart and stroke patients.
- Improve access to preconception and prenatal care for women of reproductive age to reduce modifiable risk factors for congestive heart disease.
- Protect individuals undergoing genetic tests from discrimination of any kind.
- Strengthen nutrition standards in schools for meals and competitive foods and in all government nutrition assistance or feeding programs.
- Establish sustainable funding for tobacco cessation/prevention programs that meet or exceed Centers for Disease Control and Prevention recommendations.
- Ensure comprehensive smoking cessation benefits in Medicare, Medicaid, and other health plans.
- Establish a National Heart Disease and Stroke Surveillance Unit to produce annual reports on key indicators of progress in the prevention and management of heart disease and stroke, including progress in disparate or vulnerable populations.

Appendix B. Continued

<table>
<thead>
<tr>
<th>Measure of Cardiovascular Health</th>
<th>Advocacy/Policy Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
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<tr>
<td>Ideal for cardiovascular health:</td>
<td>Reduce sodium in the food supply</td>
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<tr>
<td>Adults: &lt;120/80 mm Hg</td>
<td>Increase funding for state heart disease and stroke prevention programs</td>
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<tr>
<td>Children: &lt;90th percentile</td>
<td>Ensure the availability of essential cardiovascular disease preventive benefits in private insurance and public health programs</td>
</tr>
<tr>
<td>Fasting plasma glucose</td>
<td>Ensure adequate healthcare coverage for early treatment and prevention of diabetes mellitus</td>
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<tr>
<td>Ideal for cardiovascular health:</td>
<td></td>
</tr>
<tr>
<td>Children and adults: &lt;100 mg/dL</td>
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</table>

FDA indicates US Food and Drug Administration.
- Advocate for robust health promotion and obesity prevention programs in early childhood programs, including Head Start.
- Address the issue of food economics so that healthy alternatives are less expensive and less nutritious foods cost more, bringing subsidies/incentives and other pricing strategies more in line with the AHA’s Diet and Lifestyle Recommendations and the Dietary Guidelines for Americans.
- Advocate for healthy food retailing in underserved areas.
- Encourage the availability, affordability, and appropriate distribution of fruits, vegetables, fiber-rich whole grains, fish (especially fatty fish), and low-fat dairy products to at-risk or vulnerable populations.

- Support the creation of and sustain existing Offices of Minority Health (or Multicultural Health) and Offices of Health Equity in state health departments.
- Secure and protect public funding and state appropriations that support eliminating health disparities initiatives.
- Secure state-level public funding for the WISEWOMAN (Well–Integrated Screening and Evaluation for Women Across the Nation) (or like) programs, which provide low-income, underinsured, or uninsured 40- to 64-year-old women with the knowledge, skills, and opportunities to improve their diet, physical activity, and other life habits to prevent, delay, or control cardiovascular and other chronic diseases.

<table>
<thead>
<tr>
<th>Writing Group Member</th>
<th>Employment</th>
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<th>Other Research Support</th>
<th>Speakers’ Bureau/Honoraria</th>
<th>Expert Witness</th>
<th>Ownership Interest</th>
<th>Consultant/Advisory Board</th>
<th>Other</th>
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<tr>
<td>Larry B. Goldstein</td>
<td>Duke University and Durham VAMC</td>
<td>None</td>
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<td>Jill Birnbaum</td>
<td>American Heart Association</td>
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<td>Timothy J. Gardner</td>
<td>Christiana Care Health System</td>
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<td>Raymond J. Gibbons</td>
<td>Mayo Clinic</td>
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| Loren Hritzka         | Cardiac, Vascular and Thoracic Surgeons Inc; Trillium Inc; Vail Resorts Inc | None | None | None | None | None | None | None |
| Neil Meltzer          | Sinai Hospital of Baltimore/Lifebridge Health | None | None | None | None | None | None | None |
| Sue Nelson            | American Heart Association | None | None | None | None | None | None | None |
| Ralph L. Sacco        | University of Miami, Neurology | None | None | None | None | None | None | None |
| Mark Schoeberl        | American Heart Association | None | None | None | None | None | None | None |
| Laurie Whitsel        | American Heart Association | None | None | None | None | None | None | None |
| Clyde W. Yancy        | Baylor University Medical Center | None | None | None | None | None | None | None |

This table represents the relationships of writing group members that may be perceived as actual or reasonably perceived conflicts of interest as reported on the Disclosure Questionnaire, which all members of the writing group are required to complete and submit. A relationship is considered to be “significant” if (a) the person receives $10,000 or more during any 12-month period, or 5% or more of the person’s gross income; or (b) the person owns 5% or more of the voting stock or share of the entity, or owns $10,000 or more of the fair market value of the entity. A relationship is considered to be “modest” if it is less than “significant” under the preceding definition.

*Modest.
†Significant.
**Reviewer Disclosures**

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<td>Julia Coffman</td>
<td>Center for Evaluation Innovation</td>
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<td>William Beaumont Hospital</td>
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<td>None</td>
<td>None</td>
<td>Smart Balance*</td>
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**References**


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American Heart Association and Nonprofit Advocacy: Past, Present, and Future: A Policy Recommendation From the American Heart Association

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