Possibilities: Optimal Cardiovascular Health for Rural Communities

Virginia Rural Health Association: 2023

Keynote Address

November 15, 2023

Eduardo Sanchez, MD, MPH,FAHA
Chief Medical Officer for Prevention
American Heart Association

Disclosure:

Principal Investigator,

National Hypertension Control Initiative

American Heart Association (AHA)
U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH)
Health Resources and Services Administration (HRSA)

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American Heart Association.

Positioning Statement:

First generation US citizen;

Son of parents (Eduardo Arturo Sanchez Medina and Carmen Mercedes Flaquer Cordero) born and raised in the Dominican Republic

AHA Mission Statement

… to be a relentless force for a world of longer, healthier lives

American Heart Association

- **Oldest and largest charitable health organization in the United States dedicated to fighting heart disease and stroke**
- **Founded in 1924 by six cardiologists**
- 3000 employees and 30 to 40 million volunteers and supporters domestically and globally
- **2nd largest funder of research related to heart disease and stroke**
- **The nation's leader in CPR education training**
- Developer and provider of science-based treatment guidelines for healthcare professionals to help them provide science-derived, evidence-based quality care to their patients.
- Provider of health education to help people understand the importance of healthy lifestyle choices.
- Known for its advocacy for changes to protect and improve the health of our communities.

Advancing Healthcare Reform: The American Heart Association's 2020 Statement of Principles for Adequate, Accessible, and Affordable Health Care: A Presidential Advisory From the American Heart Association

1. All People in the US Should Have Comprehensive, Understandable, and Affordable Health Coverage
2. All People in the US Should Receive Quality, Affordable, Patient-Centered Health Care
3. All People in the US Should Have Access to Evidence-Based Preventive Services at Low/No cost, Regardless of How They Gain Coverage
4. Race, Sex, Gender, and Geographic Disparities in Health and Health Care Must Be Eliminated
5. Public Health Infrastructure Should Be Strengthened to Respond to Social Determinants of Health, and to Support the Elimination of Systemic Inequities in Health and Health Care
6. The US Healthcare Workforce Should Continue to Grow and Diversify Through a Sustained National Commitment to Culturally Competent Public Health and Medical Education and Clinical Training
7. Support of Biomedical and Health Services Research and Adequate Funding for the NIH, CDC, and Other Health Agencies

Circulation. 2020 | Volume 141, Issue 10: e615–e644, originally published February 10, 2020,
https://doi.org/10.1161/CIR.0000000000000753.

Health of the US

Cause of Death (2022)

RANK	CAUSE
1	Heart Disease
2	Cancer
3	Unintentional injury
4	COVID-19
5	Stroke
6	Chronic lower respiratory disease
7	Alzheimer disease
8	Diabetes
9	Kidney disease
10	Chronic liver disease and cirrhosis

Ahmad FB, Cisewski JA, Xu J, Anderson RN. Provisional Mortality Data — United States, 2022. MMWR Morb Mortal Wkly Rep 2023;72:488–492. DOI: http://dx.doi.org/10.15585/mmwr.mm7218a3.

Health of Virginia

Cause of Death (2021)

In 2020, the life expectancy in VA was 77.6 years vs 77 years in the US overall.

24.2% of deaths in VA in 2021 were due to heart disease and stroke.

Rank	Cause	Number	Percent
	Total	85,940	100%
1	Heart Diseases	16,654	19.4%
2	Cancer	15,724	18.3%
3	COVID-19	8,990	10.5%
4	Accidents	5,358	6.2%
5	Stroke	4,117	4.8%
6	Chronic Lower Respiratory Disease	3,194	3.7%
7	Diabetes mellitus	2,667	3.1%
8	Alzheimer's disease	2,582	3.0%
9	Kidney disease	1,678	2.0%
10	Suicide	1,188	1.4%

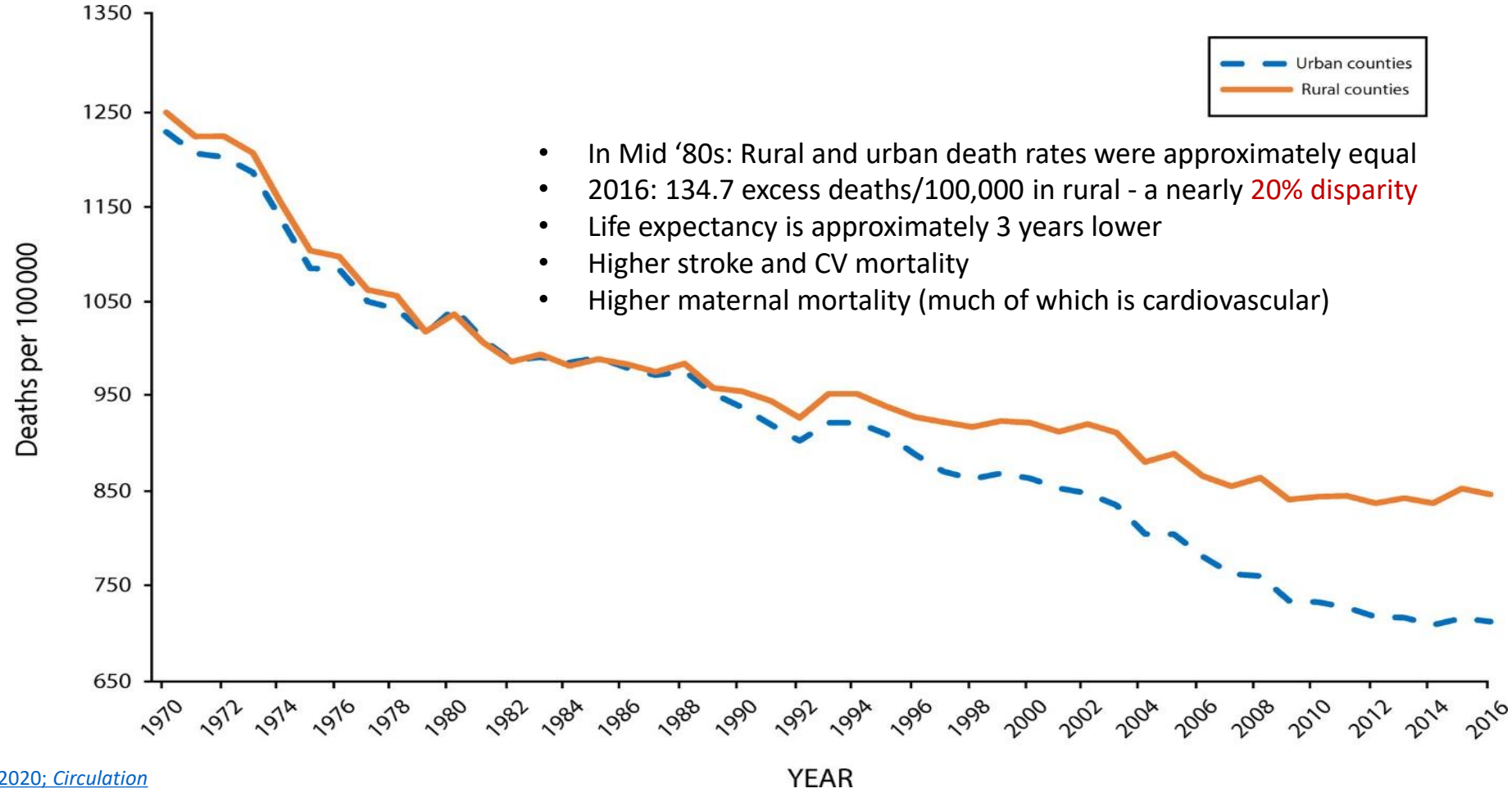
Source: CDC Wonder, Underlying Cause of Death); Accessed 11/8/2023
https://www.cdc.gov/nchs/pressroom/sosmap/life_expectancy/life_expectancy.htm; Accessed 11/8/2023

Health of Virginia:
America's Health Rankings (Virginia - 2022)

Category	Actual value	Ranking
Uninsured	7%	21
Clinical preventive services	--	19
Quality of care	--	28
Have dedicated health care provider	84%	25
Smoking	12%	13
Physical inactivity	21%	13
Fruit and vegetable consumption	7%	27
Insufficient sleep	34%	34
High speed internet	93%	18
Overall		**14**

Source: https://www.americashealthrankings.org/explore/states/TX; accessed 11/8/23

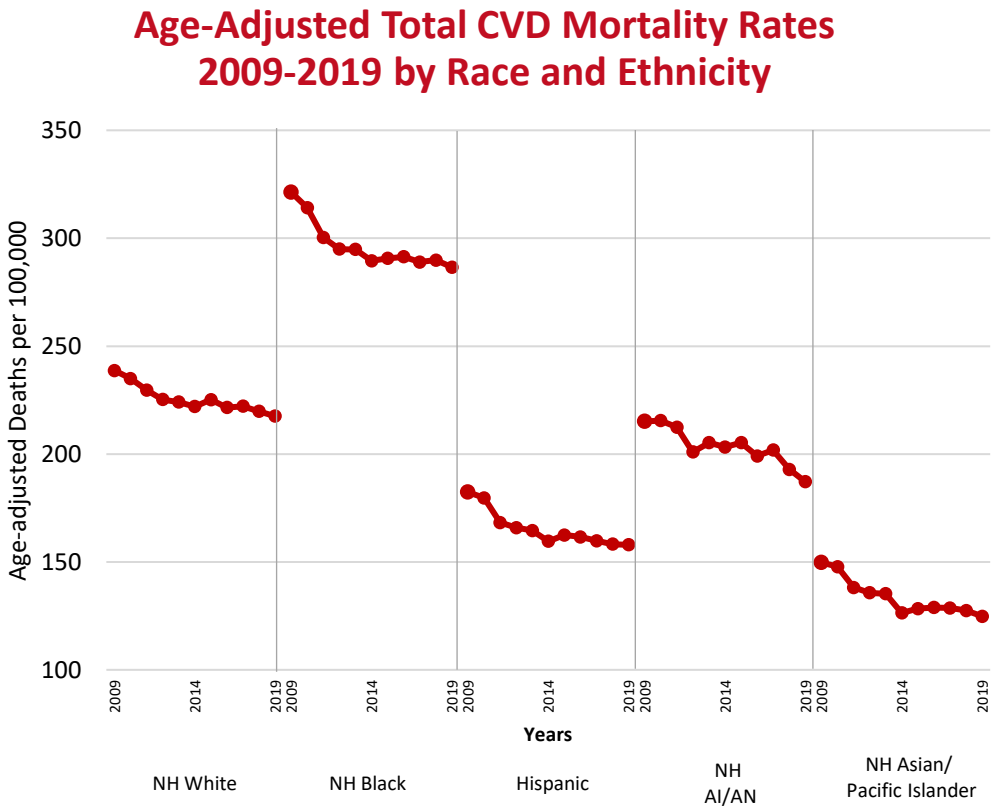
Mortality in Rural America

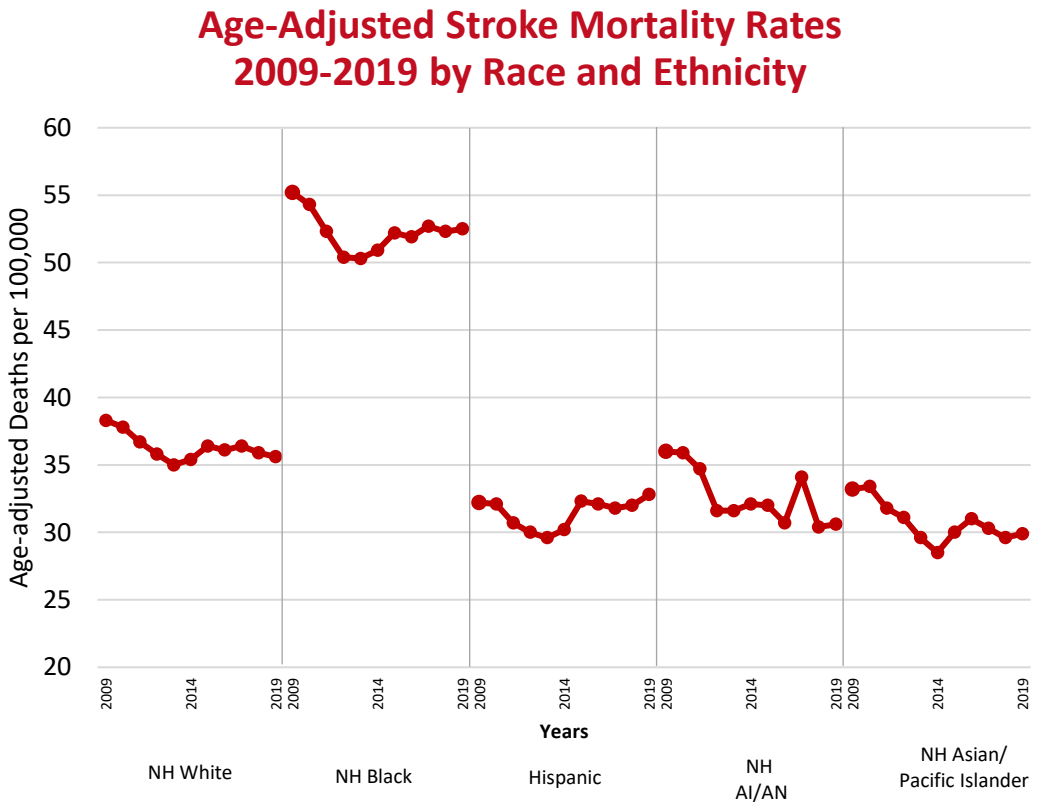


- In Mid '80s: Rural and urban death rates were approximately equal
- 2016: 134.7 excess deaths/100,000 in rural - a nearly 20% disparity
- Life expectancy is approximately 3 years lower
- Higher stroke and CV mortality
- Higher maternal mortality (much of which is cardiovascular)

Source: Harrington et al. 2020; *Circulation*

Disparities in Mortality by Race/Ethnicity (Pre-COVID)



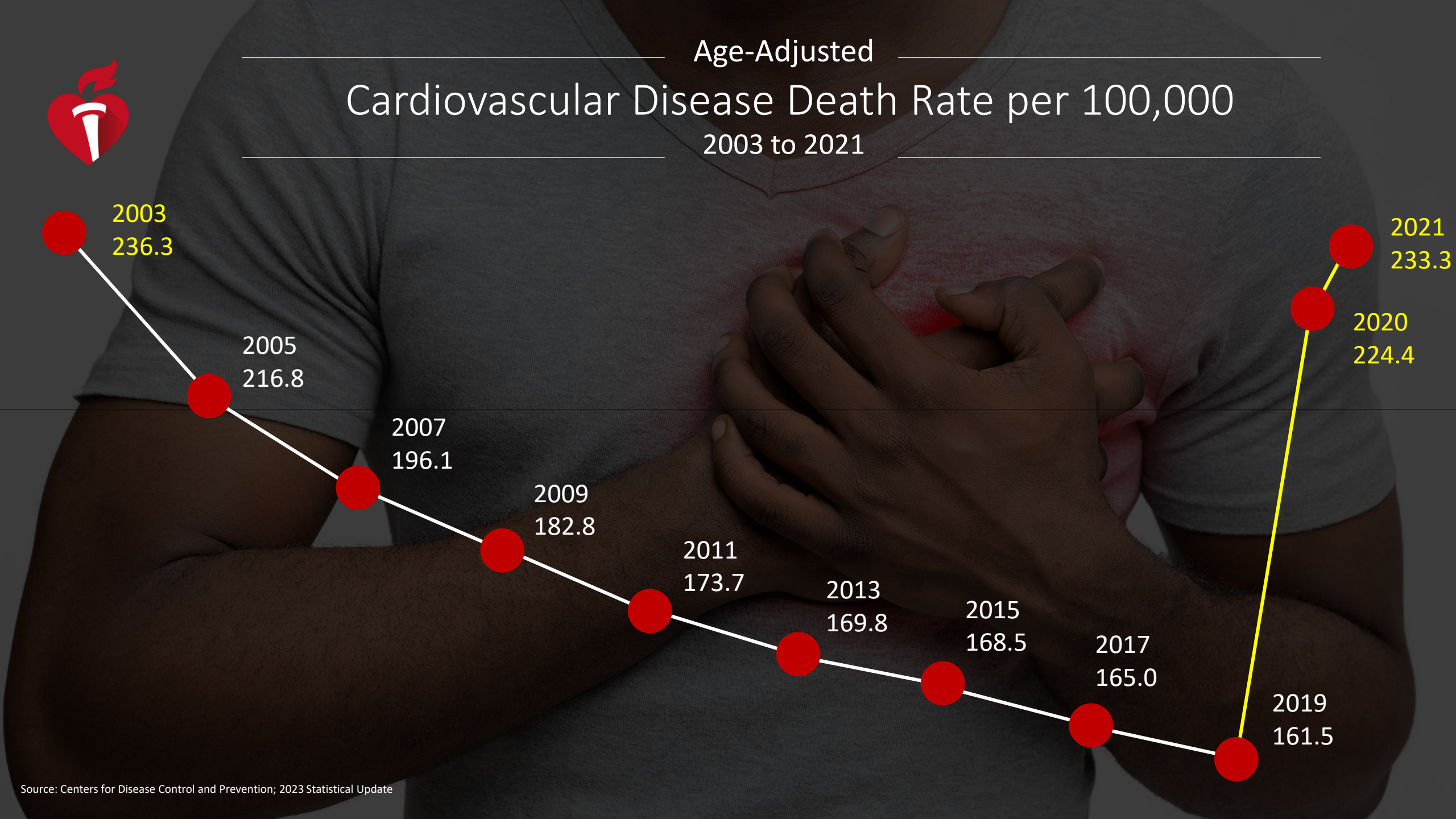


Source: CDC Wonder - NCVHS ICD-10: I00-I99, Q20-Q28

Age-Adjusted

Cardiovascular Disease Death Rate per 100,000

2003 to 2021



Source: Centers for Disease Control and Prevention; 2023 Statistical Update

Pregnancy-Related Mortality Ratio by Race/Ethnicity: 2016-2018

RURAL LIVING

Searching for solutions

Maternity care deserts force some to travel for childbirth

By CLAIRE RUSH and LAURA UNGAR
The Associated Press

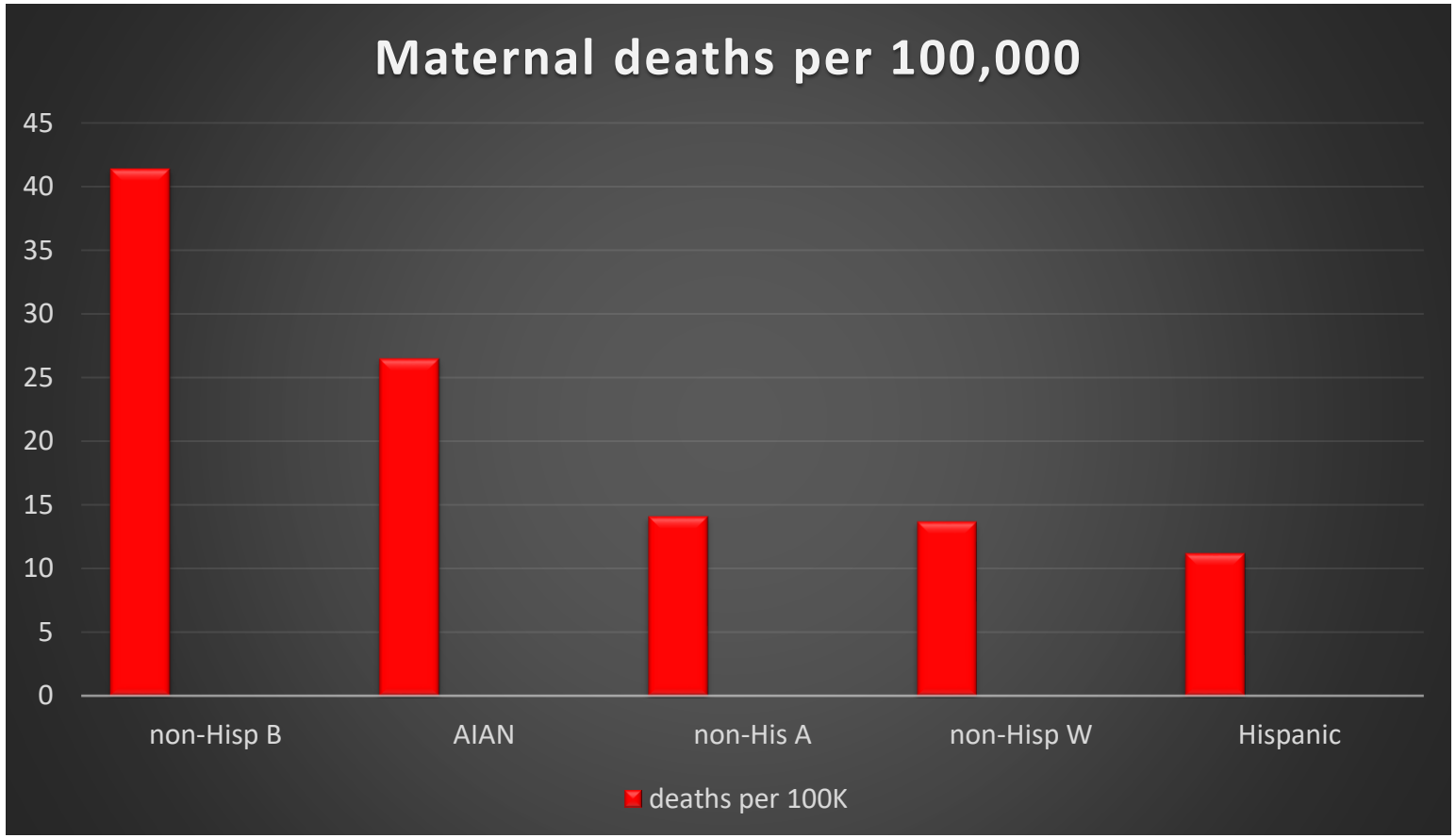
Alisha Alderson placed everything she needed for the last month of her pregnancy in various suitcases as she prepared to leave the comfort of her

More than 2 million women of childbearing age live in these areas. And fewer hospital maternity units makes having babies less safe, doctors and researchers say.

"Moms have complications everywhere. Babies have complications ev-

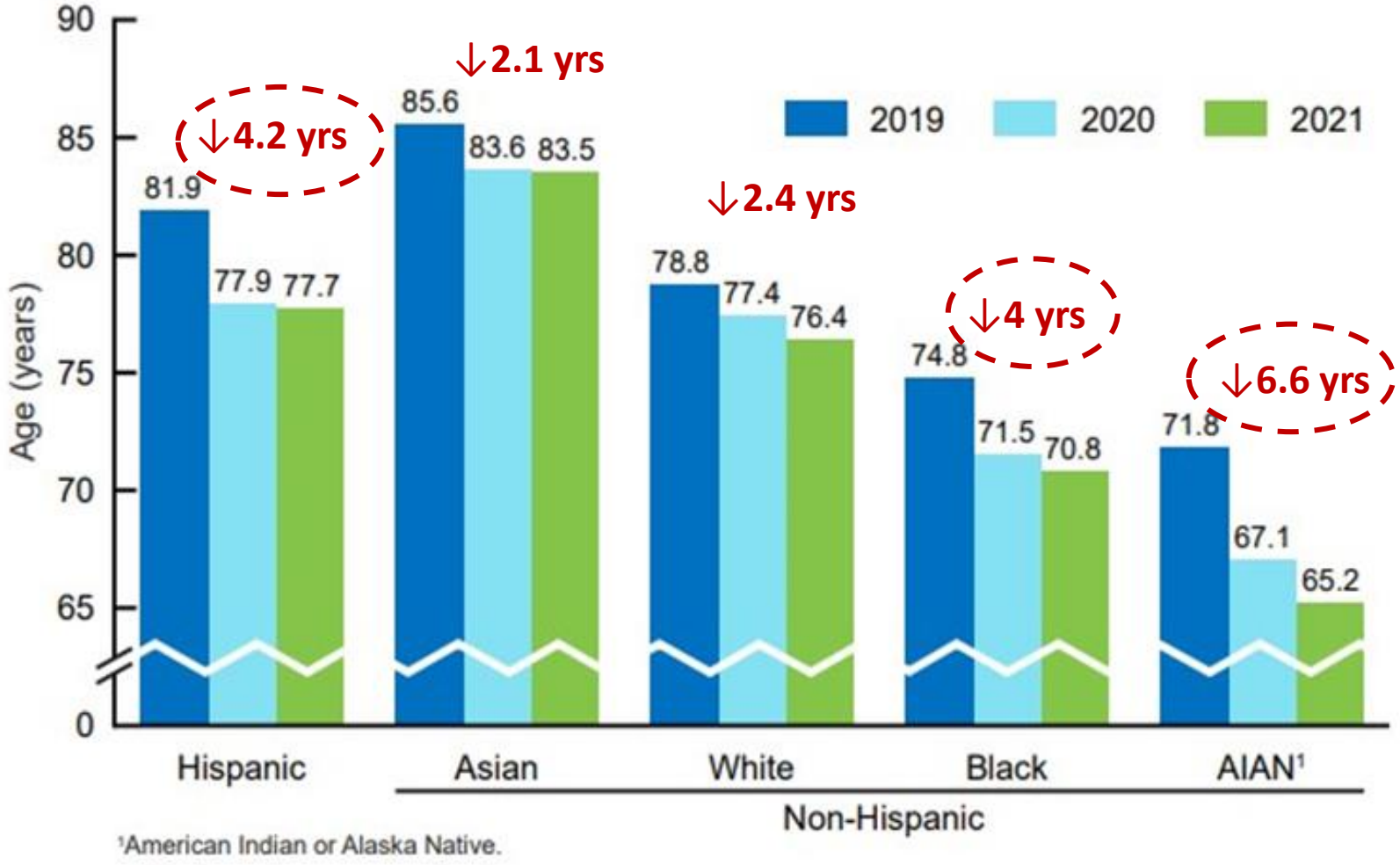
a handful of women sat in a circle for a prenatal group meeting at The Farm Midwifery Center, a storied place in Summertown, Tenn., that's more than a half-century old. Midwife Corina Fitch led discussions and gave them individual checkups.

Dallas Morning News, September 18, 2023



Source: https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm and Dallas Morning News; Print; September 18, 2023

Life Expectancy Decrease (2019, 2020, 2021)



Source: https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf; Accessed 8/31/2023

Virginia Demographics – Race and Ethnicity

2020 Census

Race/Ethnicity	Number	Percent	% Change since 2010
Total Population	8,631,393	100%	7.9%
White NH	5,696,719	66%	-2.5%
Black NH	1,760,804	20.4%	3.6%
Asian NH	681,880	7.9%	40%
American Indian and Alaska Native NH	17,263	0.2%	-7.7%
Native Hawaiian and other Pacific Islander NH*	8,631	0.1%	22.4%
Hispanic or Latino	906,296	10.5%	43.8%

*Estimates too small to be reliable
NH = Non-Hispanic

Source: VIRGINIA: 2020 Census; Accessed November 8, 2023

Seven life years gained from 1960 to 2000; mostly from lower cardiac death rates

Table 2. Causes of Increases in Life Expectancy among Newborns, 1960–2000.*

Cause	Increase in Life Expectancy	Relative Contribution
	yr	%
Reduction in rate of death from cardiovascular disease	4.88	70
Reduction in rate of death in infancy	1.35	19
Reduction in rate of death from external causes	0.36	5
Reduction in rate of death from pneumonia or influenza	0.28	4
Reduction in rate of death from cancer	0.19	3
Total	6.97	100

* The data do not sum to the total because of slight increases in the rates of death from other causes (not listed) and because of rounding.

Source: Cutler DM et al. N Engl J Med 2006;355:920-927

Leading Risk Factors for CVD

Population Attributable Fraction (PAF)

Rank	Risk Factor	PAF (95% CI)
1	**Hypertension**	**22.3% (17.4-27.2)**
2	High non-HDL cholesterol	8.1% (3.1-13.2)
3	Household air pollution	6.9% (4.7-9.1)
4	Tobacco use	6.1% (4.5-7.6)
5	Poor diet	6.2% (2.8-9.5)
6	Low education	5.8% (2.8-8.8)
7	Abdominal obesity	5.7% (1.7-9.8)
8	Diabetes	5.1% (2.9-7.4)
9	Low grip strength	3.3% (0.9-5.7)
10	Low physical activity	1.5% (0.3-2.7)

Source: Yusuf et al., Lancet, 2020

My Life Check

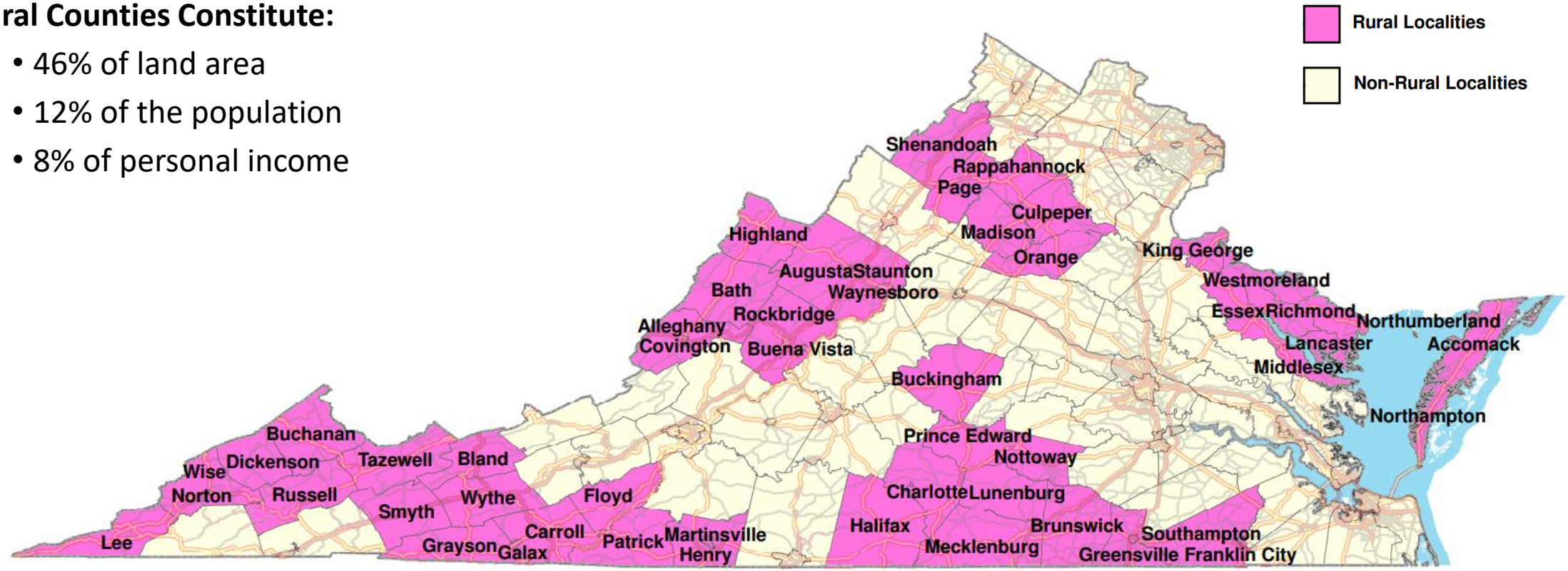
Visit https://mlc.heart.org to calculate your Life's Essential 8 Heart Health Score

Rural Counties In Virginia

Virginia State Definition Of Rural – Aligned with OMB classification of micropolitan and non-metropolitan counties as rural.

Rural Counties Constitute:

- 46% of land area
- 12% of the population
- 8% of personal income



Source: Virginia-Rural-Health-Plan_2-Defining-Rurality; Accessed November 8, 2023

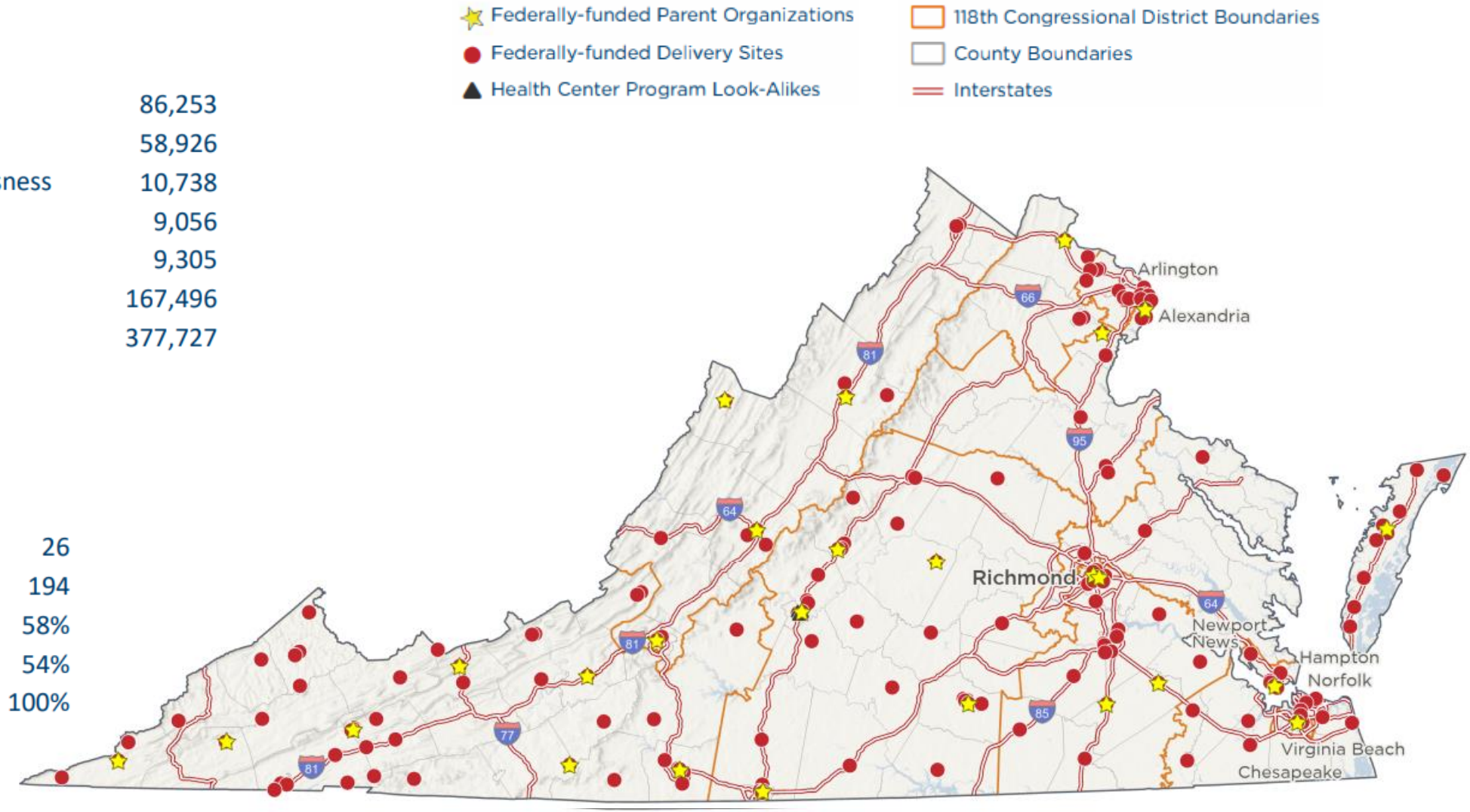
Virginia Health Centers

VA Patients

Children	86,253
Older adults	58,926
Patients experiencing homelessness	10,738
Veterans	9,056
Agricultural workers	9,305
Racial/ethnic minority	167,496
Total patients	377,727

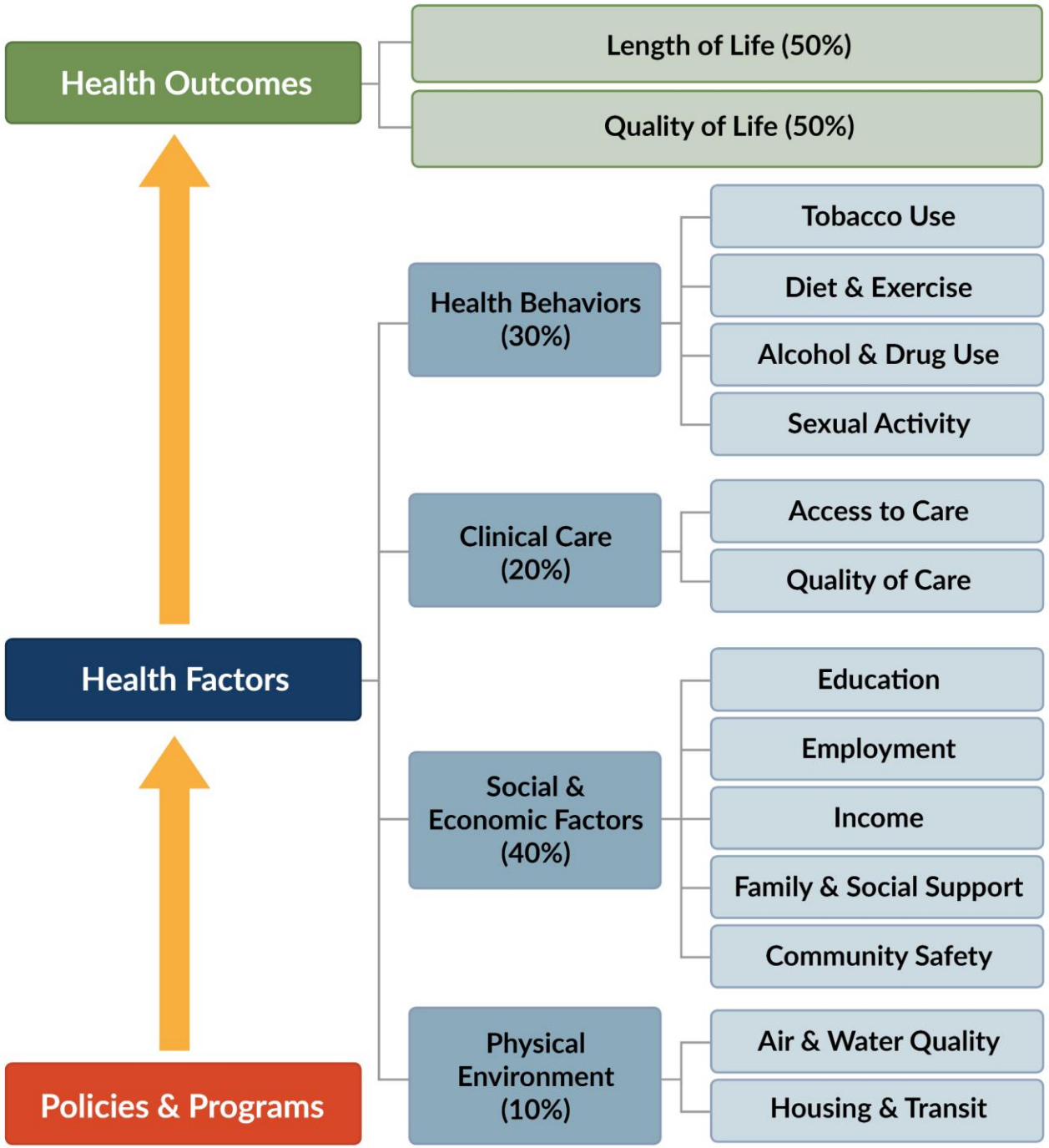
VA Health Centers

Total Grantees	26
Service Delivery Sites	194
% Rural	58%
% with MAT Services	54%
% Utilizing Telehealth	100%



Source: State Level Health Center Data & Maps - NACHC; Accessed November 8, 2023

County Health Rankings Model



Source: County Health Rankings Model | County Health Rankings & Roadmaps; Accessed 10/20/2023

Key Determinants

- Socioeconomic position
- Race, ethnicity
- Social support
- Culture and language
- Access to care
- Residential environment

AHA Scientific Statement

Social Determinants of Risk and Outcomes for Cardiovascular Disease

A Scientific Statement From the American Heart Association

Edward P. Havranek, MD, FAHA, Chair; Mahasin S. Mujahid, PhD, MS, Co-Chair; Donald A. Barr, MD, PhD; Irene V. Blair, PhD; Meryl S. Cohen, MD, FAHA; Salvador Cruz-Flores, MD, FAHA; George Davey-Smith, MA(Oxon), MD, BChir(Cantab), MSc(Lond); Cheryl R. Dennison-Himmelfarb, RN, PhD, FAHA; Michael S. Lauer, MD, FAHA; Debra W. Lockwood; Milagros Rosal, PhD; Clyde W. Yancy, MD, FAHA; on behalf of the American Heart Association Council on Quality of Care and Outcomes Research, Council on Epidemiology and Prevention, Council on Cardiovascular and Stroke Nursing, Council on Lifestyle and Cardiometabolic Health, and Stroke Council

An Institute of Medicine report titled *U.S. Health in International Perspective: Shorter Lives, Poorer Health* documents the decline in the health status of Americans relative to people in other high-income countries, concluding that "Americans are dying and suffering from illness and injury at rates that are demonstrably unnecessary."[1] The report blames many factors, "adverse economic and social conditions" among them. In an editorial in *Science* discussing the findings of the Institute of Medicine report, Bayer et al[2] call for a national commission on health "to address the social causes that have put the USA last among comparable nations."

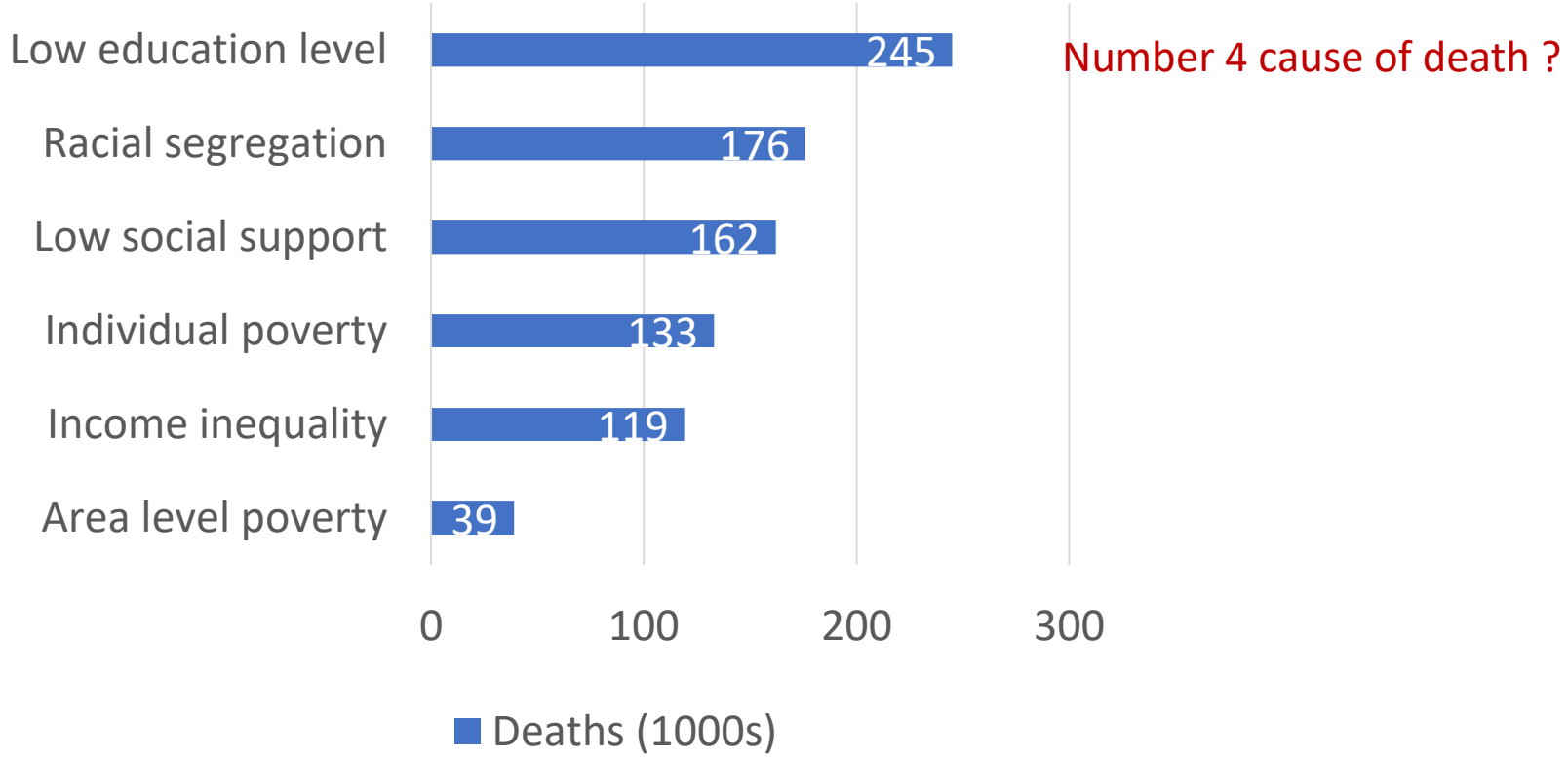
Although mortality from cardiovascular disease (CVD) in the United States has been on a linear decline since the 1970s, the burden remains high. It accounted for 31.9% of deaths in 2010.[3]

There is general agreement that the decline is the result, in equal measure, of advances in prevention and advances in

The prevalence of CVD in the United States is expected to rise 10% between 2010 and 2030.[6] This change in the trajectory of cardiovascular burden is the result not only of an aging population but also of a dramatic rise over the past 25 years in obesity and the hypertension, diabetes mellitus, and physical inactivity that accompany weight gain. Although there is no consensus on the precise causes of the obesity epidemic, a dramatic change in the underlying biology of Americans is not postulated. More likely culprits are changes in societal and environmental conditions that have led to changes in diet and physical activity. At the same time, there is increasing awareness that the benefits of advances in prevention and treatment have not been shared equally across economic, racial, and ethnic groups in the United States. Overall population health cannot improve if parts of the population do not benefit from improvements in prevention and treatment.

Source: Havranek et al, *Circulation*, 2015, 132: 873-898.

Relationship between Social Determinants and Mortality (2000)



Number 4 cause of death ?

Source: Galea et al, Estimated Deaths Attributable to Social Factors in the United States, AJPH, August 2011, Vol 101, No. 8.

Closing the Digital Divide (2016)

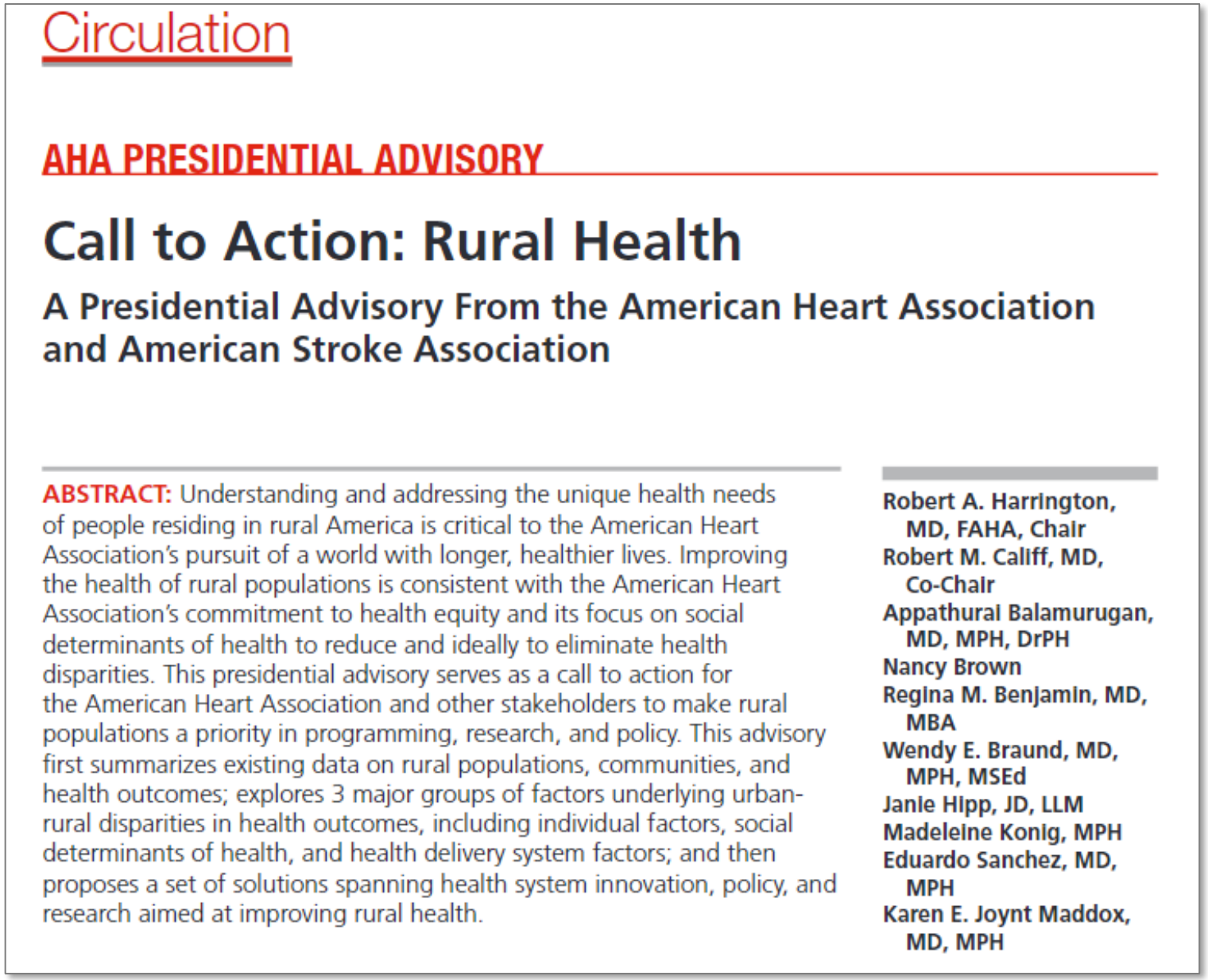
"…As the digital economy grows, digital inclusion represents economic inclusion. Yet broadband access and adoption continue to lag behind for certain population segments, including low-income and rural communities. This is referred to as the **digital divide**—i.e., the gap between people who have access to broadband services and know how to use the internet and those who do not have such access or knowledge.

The digital divide leads to further economic, social and political disparities for low-income and underserved populations".

Source: https://www.dallasfed.org/-/media/Documents/cd/pubs/digitaldivide.pdf; accessed 10/9/2023.

February 13, 2020

Presentation to the NRHA



Circulation

AHA PRESIDENTIAL ADVISORY

Call to Action: Rural Health

A Presidential Advisory From the American Heart Association and American Stroke Association

ABSTRACT: Understanding and addressing the unique health needs of people residing in rural America is critical to the American Heart Association's pursuit of a world with longer, healthier lives. Improving the health of rural populations is consistent with the American Heart Association's commitment to health equity and its focus on social determinants of health to reduce and ideally to eliminate health disparities. This presidential advisory serves as a call to action for the American Heart Association and other stakeholders to make rural populations a priority in programming, research, and policy. This advisory first summarizes existing data on rural populations, communities, and health outcomes; explores 3 major groups of factors underlying urban-rural disparities in health outcomes, including individual factors, social determinants of health, and health delivery system factors; and then proposes a set of solutions spanning health system innovation, policy, and research aimed at improving rural health.

Robert A. Harrington, MD, FAHA, Chair
Robert M. Califf, MD, Co-Chair
Appathurai Balamurugan, MD, MPH, DrPH
Nancy Brown
Regina M. Benjamin, MD, MBA
Wendy E. Braund, MD, MPH, MSEd
Janie Hipp, JD, LLM
Madeleine Konig, MPH
Eduardo Sanchez, MD, MPH
Karen E. Joynt Maddox, MD, MPH

Source: Harrington et al. 2020; *Circulation*

American Heart Association.

November 2020

Circulation

AHA PRESIDENTIAL ADVISORY

Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

A Presidential Advisory From the American Heart Association

ABSTRACT: Structural racism has been and remains a fundamental cause of persistent health disparities in the United States. The coronavirus disease 2019 (COVID-19) pandemic and the police killings of George Floyd, Breonna Taylor, and multiple others have been reminders that structural racism persists and restricts the opportunities for long, healthy lives of Black Americans and other historically disenfranchised groups. The American Heart Association has previously published statements addressing cardiovascular and cerebrovascular risk and disparities among racial and ethnic groups in the United States, but these statements have not adequately recognized structural racism as a fundamental cause of poor health and disparities in cardiovascular disease. This presidential advisory reviews the historical context, current state, and potential solutions to address structural racism in our country. Several principles emerge from our review: racism persists; racism is experienced; and the task of dismantling racism must belong to all of society. It cannot be accomplished by affected individuals alone. The path forward requires our commitment to transforming the conditions of historically marginalized communities, improving the quality of housing and neighborhood environments of these populations, advocating for policies that eliminate inequities in access to economic opportunities, quality education, and health care, and enhancing allyship among racial and ethnic groups. Future research on racism must be accelerated and should investigate the joint effects of multiple domains of racism (structural, interpersonal, cultural, anti-Black). The American Heart Association must look internally to correct its own shortcomings and advance antiracist policies and practices regarding science, public and professional education, and advocacy. With this advisory, the American Heart Association declares its unequivocal support of antiracist principles.

Keith Churchwell, MD, FAHA, Chair
Mitchell S.V. Elkind, MD, MS, FAHA
Regina M. Benjamin, MD, MBA
April P. Carson, PhD, MSPH, FAHA
Edward K. Chang, BS
Willie Lawrence, MD, FAHA
Andrew Mills, MPH
Tanya M. Odom, EdM
Carlos J. Rodriguez, MD, MPH, FAHA
Fatima Rodriguez, MD, MPH, FAHA
Eduardo Sanchez, MD, MPH
Anjail Z. Sharrief, MD, MPH, FAHA
Mario Sims, PhD, MS, FAHA
Olajide Williams, MD, MS
On behalf of the American Heart Association

Source: Churchwell et al. 2020; *Circulation*

American Heart Association.

2024 IMPACT GOAL

Every person deserves the opportunity for a full, healthy life. As **champions for health equity***, by 2024, the American Heart Association will advance cardiovascular health for all, including identifying and removing barriers to health care access and quality.

Addressing the drivers of health disparities, including the social determinants of health, structural racism,

and rural health inequities,

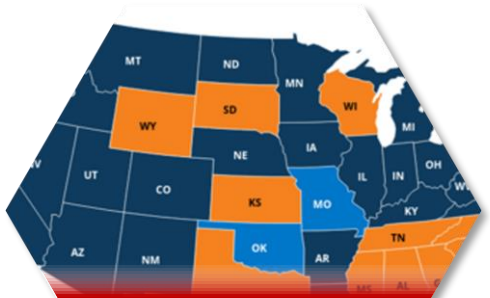
is the only way to truly achieve equitable health and well-being for all.

AHA's 10 Commitments

To Address the Drivers of Health Disparities including Social Determinants of Health and Structural Racism


Research


Community



Access to Care


Targeting Industry


Hypertension


Quality Initiatives


Workplace Roadmap


Health Professionals Learning Platform

Journals


AHA Workforce Diversity

Source: AHA 10 Commitments

Health Equity Research Network on Improving Access to Care and other Health Inequities in Rural America

Reciprocal Innovations to Improve Cardiovascular Care in Rural America (Rural PRO-CARE), the name of the overarching research network's coordinating center, will be managed by a team from University of Washington School of Medicine, led by Chris Longenecker, MD, FAHA.

- Implementation and Scale-up of the American Indian Structural Heart Disease Partnership (IN-STEP) at Children's Hospital Medical Center in Cincinnati, Ohio, led by Andrea Beaton, MD, MS, FAHA
- Developing and Testing Drone-Delivered AEDs for Cardiac Arrests In Rural America at Duke University School of Medicine in Durham, North Carolina, led by Monique Starks, MD, MHS.
- Rural Community Peer Partnerships for Improving Methamphetamine-Associated Heart Failure Screening and Engagement at Oregon Health & Science University in Portland, led by Todd Korthuis, MD, MPH.
- Implementation and Evaluation of Pharmacist-Based Management of Chronic Heart Failure for Rural Veterans (PHARM-HF) at VA Palo Alto Health Care System in Palo Alto, California, led by Paul Heidenreich, MD, MS, FAHA.
- GROW-RURAL: A Global to Rural Innovation Network to Adapt Evidence-Based Cardiovascular Interventions to Context at University of Washington School of Medicine in Seattle, led by Chris Longenecker, MD, FAHA.

Source: Health Equity Research Network (HERN) on Improving Access to Care and other Health Inequities in Rural America - Professional Heart Daily | American Heart Association

Health Equity Research Network on Prevention of Hypertension

RESTORE (AddREssing Social Determinants TO pRevent hypErtension) Network, the name of the overarching research program, will be managed by a multidisciplinary team from NYU Grossman School of Medicine.

- **Groceries for Black Residents to Stop Hypertension (GOFRESH)** at Beth Israel Deaconess Medical Center in Boston - Led by Stephen P. Juraschek, M.D., M.P.H.
- **Home Blood Pressure Telemonitoring Linked with Community Health Workers to Improve Blood Pressure (LINKED-BP)** at Johns Hopkins University School of Nursing in Baltimore – Led by Yvonne Commodore-Mensah.
- **Community-to-Clinic Implementation Program (CLIP)** at NYU Grossman School of Medicine - Led by Joseph Ravenell, M.D.
- **Linkage, Empowerment, and Access to Prevent Hypertension (LEAP-HTN)** at Wayne State University in Detroit – Led by Phillip Levy, M.D., M.P.H.
- **Equity in Prevention and Progression of Hypertension by Addressing barriers to Nutrition and Physical Activity (EPIPHANY)** at UAB– Led by Andrea Cherrington, M.D., M.P.H.

Source: https://professional.heart.org/en/research-programs/aha-funded-research/health-equity-research-network-on-prevention-of-hypertension

Health Equity Research Network on
Disparities in Maternal-Infant Health Outcomes

P3 (Pregnancy and Postpartum/Postnatal) EQUATE (Enhancing Access and QUAlityTo Achieve Equitable Maternal and Infant Health), the name of the overarching research network's coordinating center, will be managed by a team from UAB) led by Alan T. Tita, M.D., Ph.D., M.P.H.

- **A community-engaged approach to understanding the impact of structural racism on maternal health equity** at Northwestern University – led by Kiarri Kershaw, Ph.D., M.P.H., M.S.
- **Better birth outcomes and Experiences Through Technology, Education and Reporting (BETTER)** at The Ohio State University (OSU) – led by Ann Scheck McAlearney, Sc.D., M.S.
- **P3 Providing an Optimized and emPowered Pregnancy for You (POPPY)** at UAB – led by Rachel G. Sinkey, M.D. and Wally Carlo, M.D..
- **Building Equitable Linkages with Interprofessional Education Valuing Everyone (BELIEVE)** at the University of North Carolina at Chapel Hill (UNC-CH) in collaboration with North Carolina Agricultural and Technical State University (N.C. A&T)– led by Alison M. Stuebe, M.D., M.Sc. and Kimberly D. Harper, M.S.N., R.N., M.H.A.and by Kimberly C. Harper, Ph.D. and Janiya Mitnaul Williams, M.A., IBCLC, CLC,
- **Implementation and Evaluation of a Perinatal CV Risk-Assessment Algorithm to Improve Maternal and Infant Health During Pregnancy, Peri & Postpartum: IMPACT P3** at the University of Philadelphia - led by Lisa D. Levine, M.D., M.S.C.E. and Abike James, M.D.

Source: https://professional.heart.org/en/research-programs/aha-funded-research/health-equity-research-network-on-disparities-in-maternal-infant-health

Rationale for Rural Health Call to Action

- In recent years, declines in cardiovascular mortality have stalled, and some cardiovascular conditions, such as stroke and heart failure, are showing increasing death rates. The decrements have been worst for persons living in rural counties in the US, where both overall and cardiovascular mortality are rising.

- Given AHA's commitment to health equity and longer, healthier lives its focus on social determinants of health, the Advisory serves as a call to action for the AHA and other stakeholders to make rural health a priority

Source: Harrington et al. 2020; *Circulation*

Social Factors - Rural

Social Determinants of Health and Rural America

Inequalities in cardiovascular health, in part, relate back to the ways in which social determinants of health can negatively impact rural populations as compared to urban and suburban populations:

Income
Median household income $10K less

Education
Fewer years of education beyond high school

Employment
Slower job growth and higher unemployment

Housing
Limited rental options

Transportation
Limited transportation options for day to day and medical needs

Food Insecurity
Fewer available food stores and affordable food options

Source: Harrington et al. 2020; *Circulation*

1) What Are Some Solutions?

Workforce Expansion

- Postsecondary education access, basic and medical
- Loan forgiveness

Fostering Rural-specific Team-Based Care

- Community paramedicine
- Role of pharmacists
- Community Health Workers

Source: Harrington et al. 2020; *Circulation*

2) What Are Some Solutions?

Exploring New Models and Sites of Care Delivery

- Expand CAHs, FQHCs, RHCs, health department services, VA facilities, IHS capacity
- Regionalization of care, hub and spoke
- Digital health and Telehealth
- Internet connectivity

Sustainable Funding Models and Flexible Payment

- “Essential cardiovascular services” – expanded essential community provider designations
- Global budgeting approaches

Source: Harrington et al. 2020; *Circulation*

3) What Are Some Solutions?

Insurance Coverage

- Medicaid Expansion
- Market reforms such as broadening rating areas

Broader Economic Development and Sustainability Efforts

- Health care–anchored economic empowerment zones, which could serve the dual need of preserving access to health and health care while driving broader economic development.
- Models that tie into rural “health hubs” might provide economies of scale for personnel and electronic health record infrastructure

Source: Harrington et al. 2020; *Circulation*

Research Needs and Gaps

- Effectiveness and scalability of new delivery models
- Better data collection on quality and outcomes (many measures currently excluded) including rural-specific measures
- Composition of, and competencies for, team-based care
  - Effectiveness of new clinician roles, responsibilities, arrangements
- Community-centered and -initiated research
- Better understanding of the health effects of policies that address economic and social factors

Source: Harrington et al. 2020; *Circulation*

AHA Action

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- Medicaid expansion
- HERN
- Get with the Guidelines – Rural Health Accelerator
- Mission: Lifeline
- Blood Pressure Control Programs – Target: BP and NHCI
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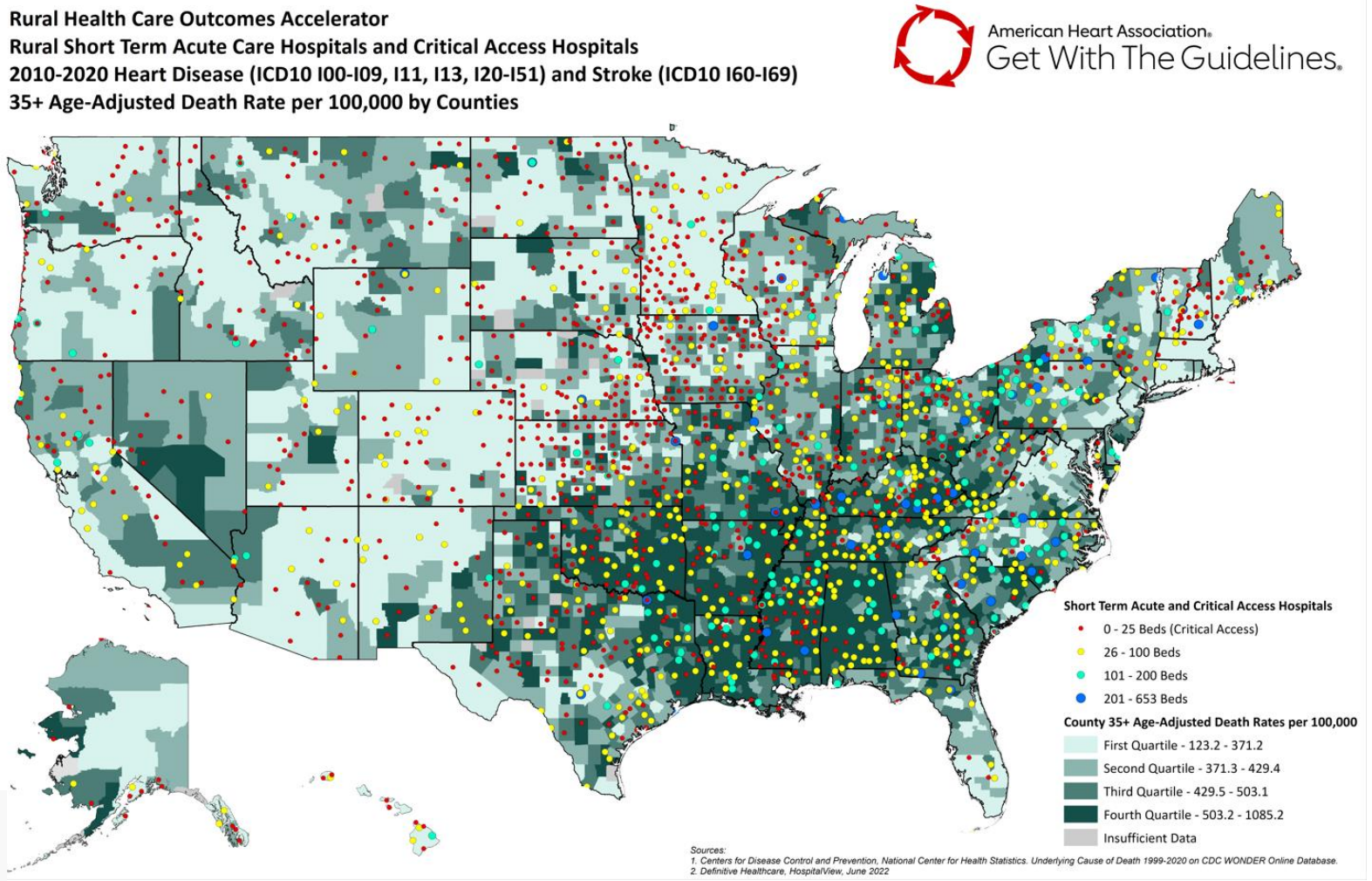
Rural Health Care Outcomes Accelerator

- **Rural Accelerator Hospital Eligibility**
- Federally Designated Critical Access Hospital OR
- Short-Term Acute Care Facility located within a Rural Urban Commuting Area (RUCA) Rural Classifications: Large Rural, Small Rural, or Isolated.
- Enrolling in a New Get with the Guidelines® module(s)
  - Stroke
  - CAD
  - Heart Failure

- Rural Health Care Outcomes Accelerator Web Page



Closing the Gap in Rural Outcomes

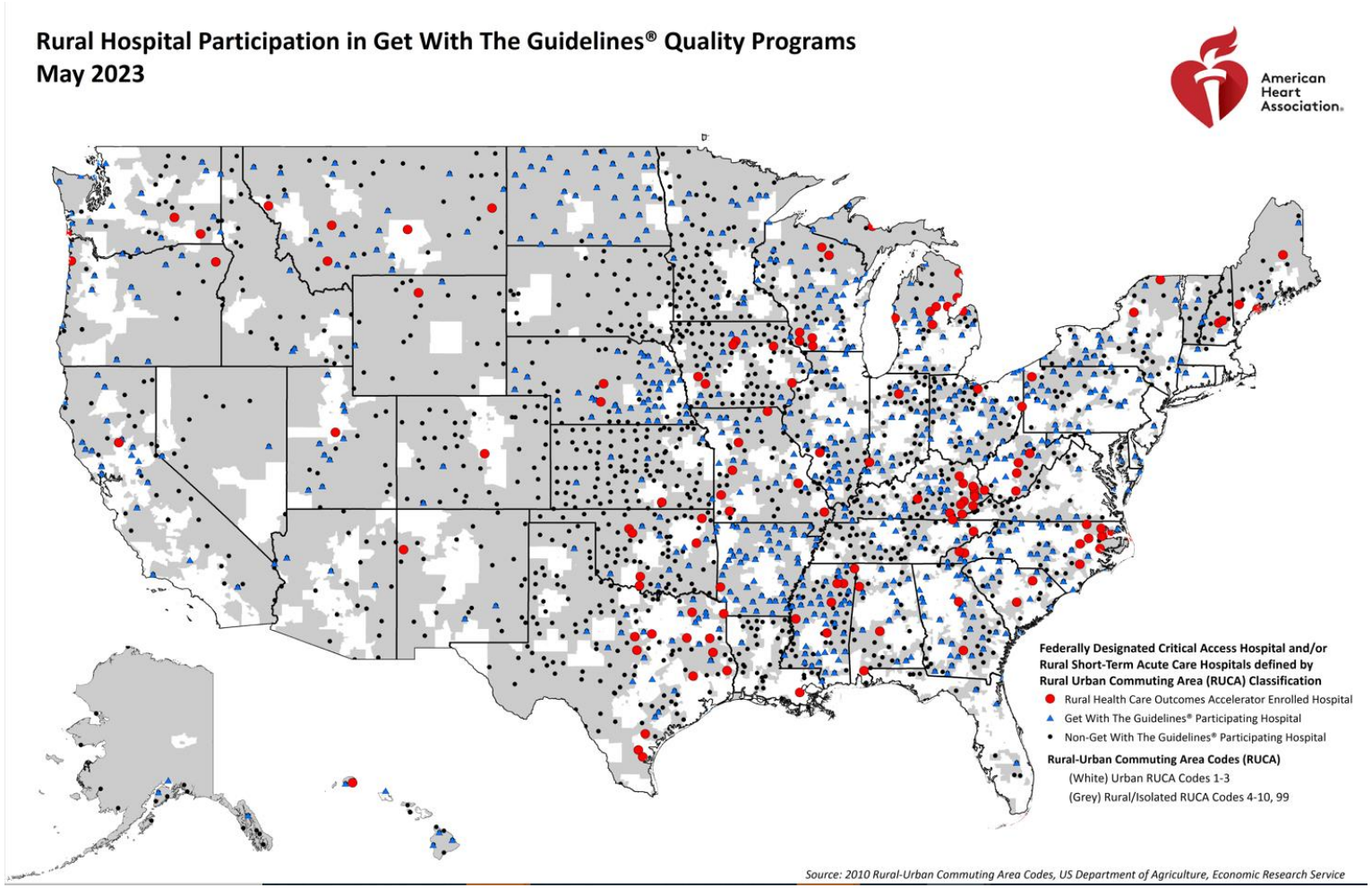
Recent healthcare metrics demonstrate a concerning trend: rural Americans face higher mortality rates than urban residents. Data indicates that rural residents are at 30% higher risk of stroke, 40% more likely to develop heart disease and live an average of three years fewer than urban counterparts.

The American Heart Association is committed to bringing equitable care to all. For that reason, we are focused on closing the gap between rural and urban hospital care as a top priority.

Find your Rural Program Eligibility at Am I Rural? Tool - Rural Health Information Hub *Provided by the Health Resources and Services Administration (HRSA)*

Rural Accelerator Program Year 1 Update

- 204 Rural Accelerator Hospital Quality Program Enrollments from July 1, 2022 – June 30, 2023
- 1005 Rural Hospitals Participating in GWTG Quality Programs
- 180+ Clinical Stoke and Cardiac Continuing Education Credits
- 300+ Members Rural Community Network
- 600+ Participants in Rural Cardiac and Stroke Quarterly Learning Collaboratives
- 115 AHA Professional Memberships Issued
- 800+ Registrants GWTG CAD & Stroke Rural Launch Webinars
- GWTG Stroke, Coronary Artery Disease and Heart Failure Rural Benchmarking Groups Established
- GWTG Stroke and Coronary Artery Disease Recognition Program Release



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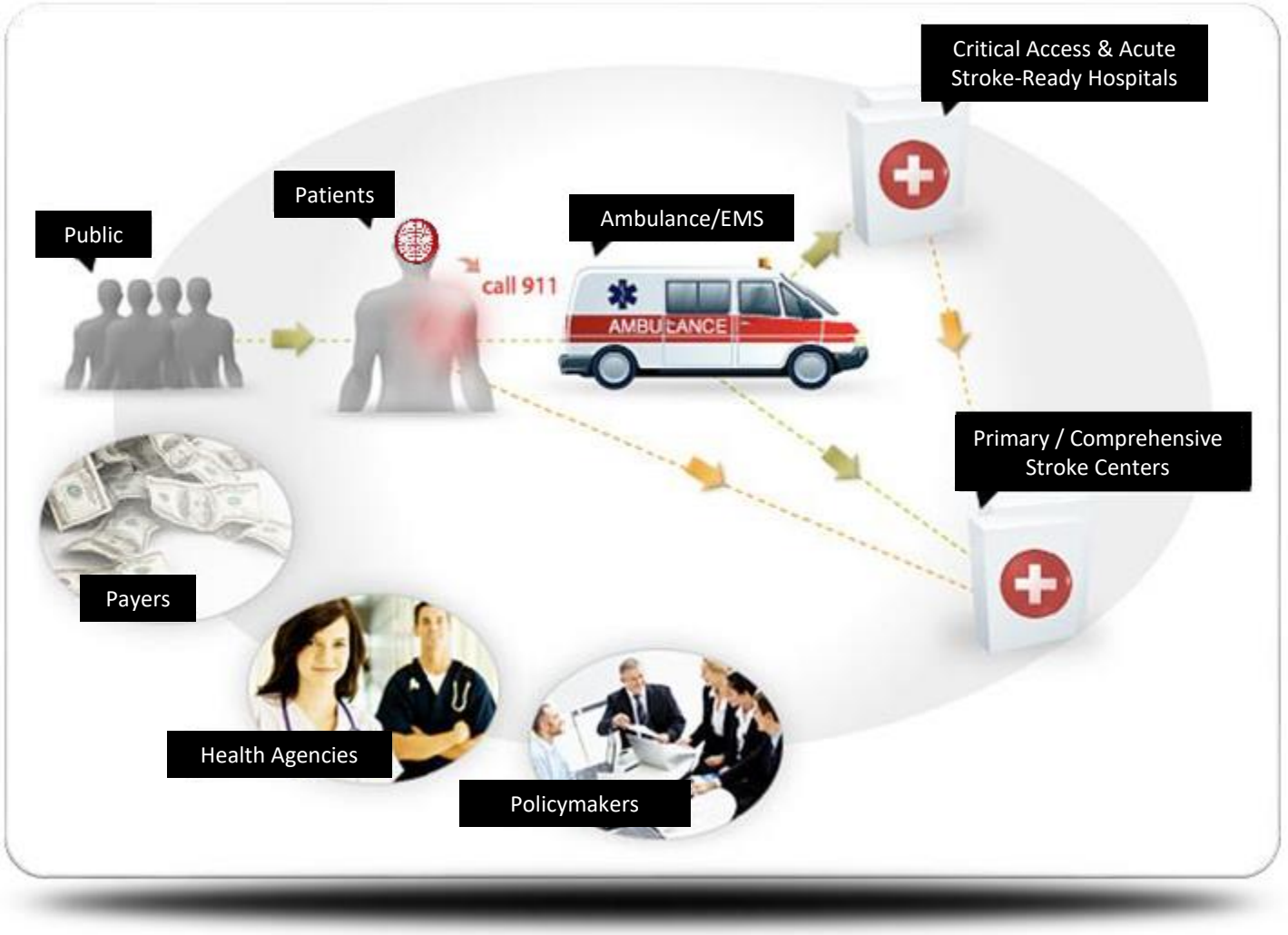
Working For Better Care In Rural Areas

Mission: Lifeline Stroke



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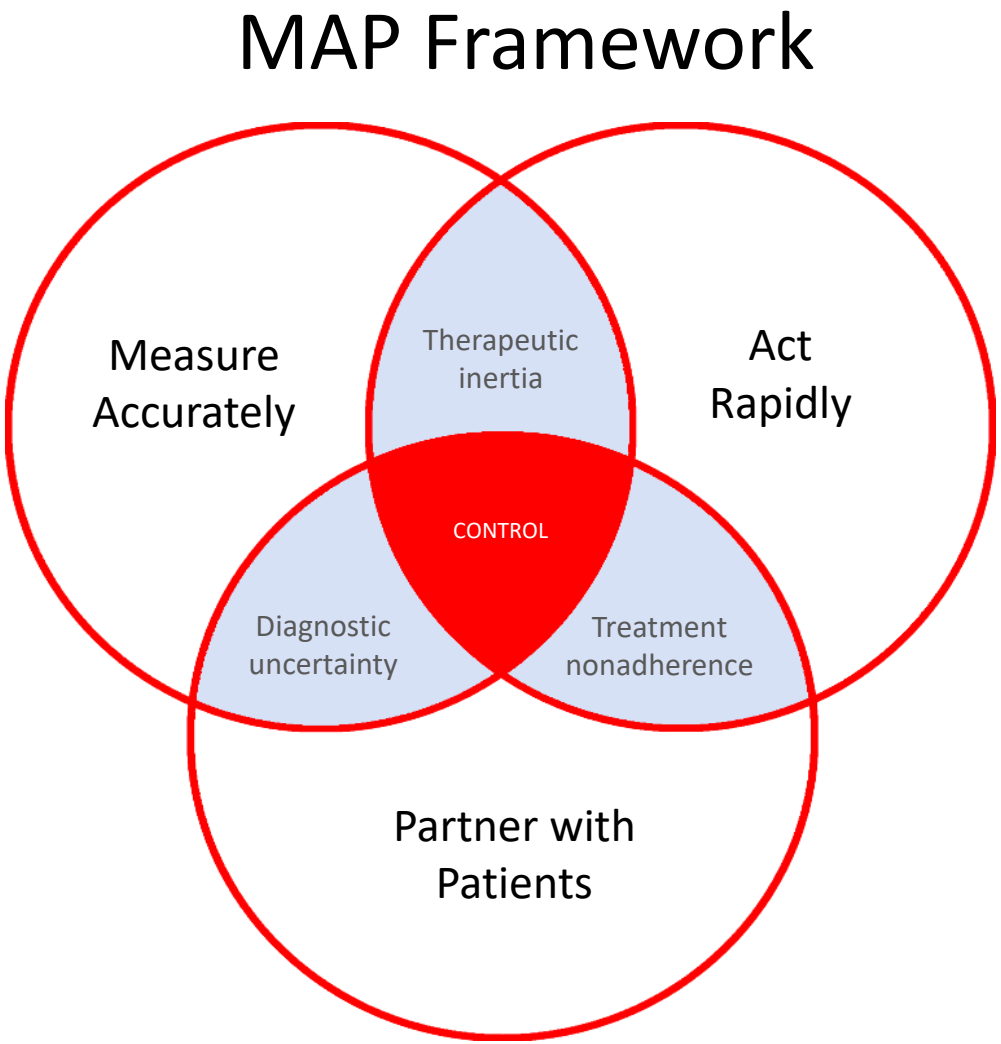
Target: BP Engagement & Achievement

Since launching the Recognition program in 2017, participation has grown from 300 to 1800 organization, now serving 8.6M patients with hypertension.

Despite dips during the pandemic, more organization are achieving higher levels or recognition – with nearly 1500 attesting to evidence-based activities and 800+ achieving control rates of 70% or higher in 2022.



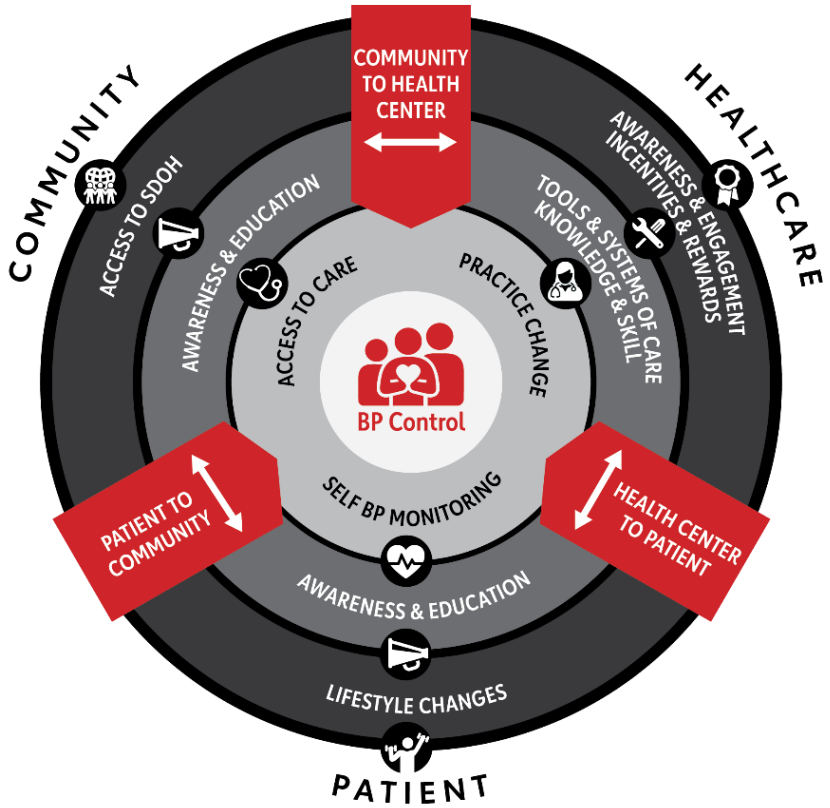
National Hypertension Control Initiative

Notification – December 2020
Purpose

To improve hypertension control and COVID-19 outcomes in health centers and communities across the U.S. with a particular focus on populations disproportionately impacted by hypertension, including Black, Hispanic, American Indian and Alaskan Natives and persons with hypertension disproportionally impacted by COVID-19 through broad scale, multi-sector, culturally sensitive and diverse evidence-based interventions, including Self Measured Blood Pressure monitoring (SMBP).

Serves an estimated 1,500,000 to 1,875,000 persons with stage 2 hypertension in ~350 HRSA-funded health centers.

104 0f 350 health centers are rural centers
(AHA NHCI Year 2 Evaluation Report to OMH and HRSA).



Learn More at https://www.heart.org/en/national-hypertension-control-initiative

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Join the Nation of Lifesavers
HEART.ORG/NATION
NATION OF LIFESAVERS
American Heart Association®

Nation of Lifesavers Priority Areas

1. Education + Training
2. Advocacy
3. National Campaigns
4. Influencer Engagement; including National Ambassador Damar Hamlin
5. NFL + NFL Clubs (Smart Heart Sports Coalition)
6. Alliances + Community Support

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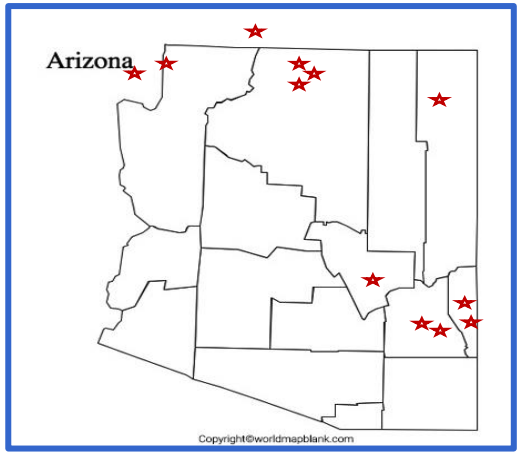
Working For Better Care In Rural Areas

- **HeartCorps** - funded by Public Health AmeriCorps, deploying up to 100 community health service members to areas across the country, prioritizing rural areas with high rates of cardiovascular disease or uncontrolled blood pressure, increased social vulnerability and shortages of health workers.

One NHCI Success Story

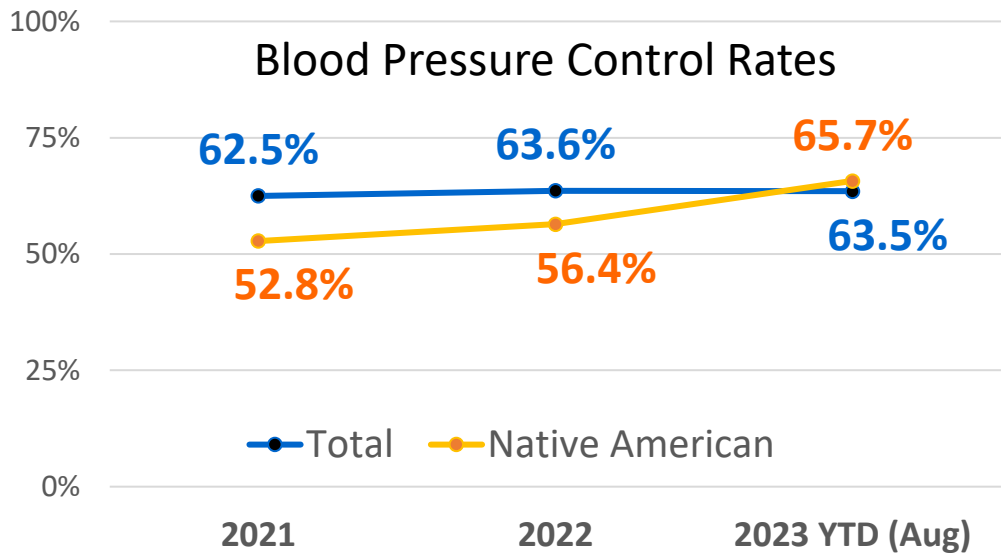
Rural Arizona



Culturally Relevant Care and Equitable Health Outcomes

CARE

- Program design
- Staff training
- Patient education resources
- Team-based care
- Patient outreach, follow-up
- **Navajo CHW**



TECH

- *McKesson Remetric Health:* RPM with validated, Bluetooth device, patient App / Care Team Portal
- *NextGen:* EHR w/manual input of SMBP values from portal
- *Azara:* Population health tool for data stratification

American Heart Association.

American Heart Association.

Increasing Healthy Life Expectancy in Rural USA

To achieve the American Heart Association's new 2024 Impact Goal
to equitably increase healthy life expectancy,
we must address the unique health needs of people in rural USA.

Acknowledgements

Thank you to Andrew Mills and Angela Agens.

American Heart Association.

“I’m not an optimist.
I’m a very serious possibilist.”

Hans Rosling (1948-2017)