Heart Disease & Stroke Public Policy in Minnesota

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MINNESOTA MDH DEPARTMENT of HEALTH
HDSP Minnesota Heart Disease & Stroke Prevention Unit

Contents

Introduction

> "Health problems are heavily influenced by societal policies and environments that in some way either sustain the behaviors and practices that contribute to the problems or fail to foster healthier choices that could prevent the problems. The major public health problems of our time will not be solved solely by individual actions and health choices, but by individuals coming together to make our society one in which healthy choices are easy, fun, and popular.
>
> What does this mean, then for public health practitioners and the agencies in which they work? So many of our programs have been aimed at changing individual behaviors. Only recently has there been a growing sense of the importance of broader societal trends and policies that affect behaviors…it is becoming increasingly clear that public health practioners must address these policies, these environments, and the support and obstacles they provide relative to healthy behaviors as the fundamental means of intervention."[1]
>
> - James S. Marks, MD, MPH
> (Former) Director, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Systems-level change, through policy and environmental change, is rapidly being established as an effective public health strategy. Individual-based behavior and treatment interventions, while essential, are not feasible as sustainable population-wide, public health solutions to disease prevention and control. A more effective public health strategy has evolved: developing, implementing, and enforcing effective policies to influence and support the prevention – and treatment – of chronic diseases, including heart disease and stroke. State heart disease and stroke prevention programs are encouraged by the Centers for Disease Control and Prevention (CDC) to address heart disease and stroke prevention and control in their states through policy development. Working together with partners in the community, state heart disease and stroke prevention programs can promote and develop policies in different settings and at various levels.

To guide this work, however, it is important to know the gaps in policies affecting heart disease and stroke. In order to understand these gaps, an inventory (or "scan") of current heart disease and stroke-related policies should be conducted (and in fact is a required activity for all CDC-funded state heart disease and stroke prevention programs). In theory, knowing what exists on the books can and should drive efforts to establish policies in those areas for which policies are absent.

This purpose of this report is twofold: first to report on the results of a scan of Minnesota statutes for heart disease and stroke-related polices, and second, to be an practical addendum to *Taking Action for Heart-healthy and Stroke-free States: A Communication Guide for Policy and Environmental Change*. (CDC, 2004). Users of this report may include state heart disease and stroke prevention program staff; members of state heart disease or stroke prevention steering committees, task forces, coalitions, and alliances; or individuals and organizations interested in policy change and heart disease or stroke prevention.

Chapter 1 focuses on what "policy" is and its various subtypes. This chapter also includes a description of the use of "prevention" levels as a framework for public health intervention and

[1] Policy and Environmental Change: New Directions for Public Health. Association of State and Territorial Directors of Health Promotion and Public Health Education and US Centers for Disease Control and Prevention. Final Report. August 2001.

action. This discussion is intended to set the stage for clarifying the topics that policies may address, and why this report focuses on what it does.

Chapter 2 describes the results from a scan of public policies in Minnesota related to the priority areas of the state heart disease and stroke prevention program at the Minnesota Department of Health. A short discussion of public policy regarding non-priority areas accompanies this section.

Chapter 3 includes recommendations for specific topics and areas for policy development. These are separated into issues to be considered by the Minnesota Heart Disease and Stroke Prevention Steering Committee and the Minnesota Stroke Partnership, and the Minnesota Heart Disease and Stroke Prevention Unit at the Minnesota Department of Health.

The Epilogue provides guidance in framing and approaching the issue of policy development. This section is intended primarily for state heart disease and stroke prevention program staff, but non-state government heart disease and stroke prevention stakeholders can also benefit from following this framework.

Chapter 1: Policy and Prevention Levels

A. Policy: Definitions and Types

Definitions

It is first important to clarify what is meant by "policy." Policy is a general term which includes laws, regulations, and rules – both informal and formal. There are different subtypes of policies, and settings in which they may exist:

Public policies: Laws or ordinances enacted at the federal, state, or local levels of government through a legislative process or another formal process of approval. Example: laws which establish taxes on tobacco products sold in a state.

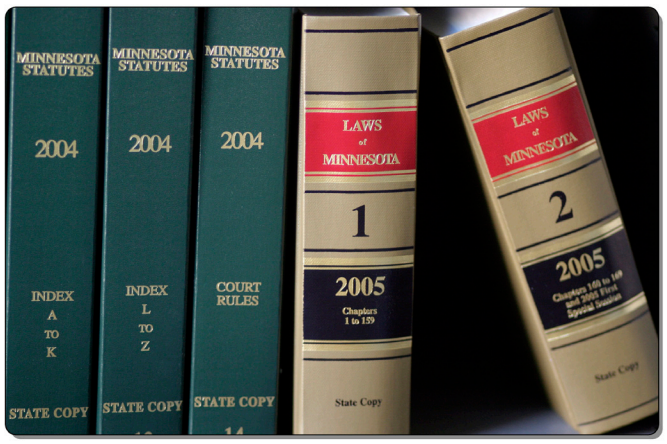
Regulatory policies: Rules and regulations created, approved, and enforced by governmental agencies, generally at the federal- or state-level. Example: The establishment by the Centers for Medicare and Medicaid of a diagnostic reimbursement group and a reimbursement schedule for payment of thrombolytic therapy for acute stroke care.

Organizational policies: Rules and procedures created, adopted, and enforced within organizations, public or private, affecting employees or members of the organization or individuals served by the organization. Organizations include (but are not limited to) private companies, health care providers, health insurance companies, national non-profit organizations, schools or entire school districts, or community groups. Example: A policy within a health insurance company that establishes that all health plans will include 100% coverage of prescription blood pressure medication costs for patients diagnosed with hypertension.

This report focuses on *public policy*, and in particular, laws enacted through the Minnesota state legislature.

Types of Heart Disease and Stroke Prevention (Public) Policies

Various types of heart disease- and stroke-related legislative action can be pursued, with varying levels of effectiveness. When discussing policy development as a strategy, often the conversation remains at a very conceptual level. This section attempts to bring specificity to the conversation. Namely, answering the question: what exactly are we talking about when we say that we want to "develop policies to address heart disease and stroke"? By describing the types of public policy (legislation), we can work from a clearer, common framework instead of a good but somewhat nebulous idea. Bringing definition to this allows us to move from high-level discussion to practical action with a common frame of reference.



In 2005, the Centers for Disease Control and Prevention Division for Heart Disease and Stroke Prevention contracted with Mathematica Policy Research, Inc. to compile a database of legislation across the country related to heart disease and stroke. The final report and database were released in October 2006. For this report, the policies compiled in this national database were reviewed and grouped into five general categories, described in Table 1.

Table 1. Types of legislative policy.

Type	Description
Proclamations	Declarations of a month or date for heart disease or stroke awareness
Research and Research Funding	Establishment of research institutes or programs; establishment of mechanisms to generate revenue to support heart disease and stroke research
Task Forces and State Plans	Establishment of task forces or state plans to address heart disease or stroke
Program Establishment and Funding	Establishment or enhancement of heart disease and stroke programs within the health department or for specific projects
Systems Impact Legislation	Establishing requirements for specific sectors, agencies, or organizations to enact changes within their respective settings which directly or indirectly address heart disease and stroke

Proclamations. Several states have "laws" or resolutions which are nothing more than proclamations and do nothing more than declare support for public awareness of heart disease and stroke. For example, they designate February as "Heart Month" or May as "Stroke Awareness Month." While this type of legislation is important for increasing recognition of heart disease and stroke as a public health problem, it is essentially only a symbolic gesture in terms of enacting lasting change for heart disease and stroke prevention.

Research and Research Funding. A few states have legislation addressing research needs and funding. While earmarking research funds is important, this type of public policy does not necessarily impact heart disease or stroke prevention directly. In addition, some states have established creative vehicles for accepting donations to support heart disease and stroke research. For example, by creating specific tax forms to allow tax payers to donate funds, or providing an option to purchase a special vehicle license plate with the additional fee going towards research support.

Task Forces and State Plans. Some states have enacted legislation to establish task forces and/or develop strategic plans to address heart disease and/or stroke. This approach may be effective in formally mobilizing stakeholders to collaboratively address heart disease and stroke in their state. Moreover, by having legislatively mandated task forces, the issue of heart disease and stroke are brought to the collective consciousness of a legislative body. As a result, this may set the stage towards developing and enacting future, more substantive legislation. However, this type of policy – by itself – is limited essentially to creating infrastructure towards addressing heart disease and stroke.

Program Establishment and Funding. Several states have legislation to provide funding (appropriations) to support their state heart disease and stroke prevention programs. Although having state health department programs supported by state funds is generally positive, this too is not public policy which *directly* impacts cardiovascular disease in the population. Similar to legislation which calls for development of a state plan, this type of public policy only provides support for leadership and infrastructure. It is only the first step towards creating and maintaining systems-level changes in the community to support heart disease and stroke prevention. Other legislation specifically establishes (and may fund) community-based projects or public awareness education campaigns. Certainly these are important, but this type of legislative action alone is not a sufficient approach to lasting, sustainable, and effective change to impact heart disease and stroke prevention, treatment, and control.

Systems Impact Legislation. Legislation which truly impacts cardiovascular health requires and supports systems-level changes. This type of public policy, if implemented and embraced, supports (or outright creates) a system-level change to direct affect the environment (social, economic, physical or otherwise) in which people live, work, learn, or play – for example, through funding and supporting the creation of biking trails, mandating minimum requirements for preventive care insurance coverage, creating physical education standards in schools, or establishing a smoke-free park system. It may serve to maximize efficiency, effectiveness, and quality of different parts of the health care system. These policies may directly affect emergency medical services agencies, health care providers, insurers, and payers, worksites and businesses, schools, or community organizations. Of the types of policy described here, systems impact public policy has the most potential to be a factor in improving the cardiovascular health in the population.

One other type of public policy worthy to be noted is an executive order. These are documented edicts by a member of the executive branch of government, usually the head (such as the governor of a state or the President of the United States). The purpose of these decrees is variable, as is the extent of their impact on the population. Sometimes they are directives to help the implementation of current legislation as the head of state sees fit. Or, they may be authorizations to certain entities or individuals to execute a program or achieve a goal as the head of state deems necessary. For example, in July 2006, Governor Tim Pawlenty of Minnesota signed an executive order to create a quality of care standards program "that will be used by the State of Minnesota in its health care purchasing policies to reward top performing providers while saving millions of dollars in health care costs." (Executive Order 06-10, Office of the Governor – see Appendix A). Executive orders, in general, have the force of law, even though they do not go through a legislative process of approval.

In summary, these distinctions between types of legislation are important to recognize. When discussing the issue of policy development among partners, this clarity in nomenclature is essential so all parties are speaking the same language.

B. Definition of Prevention Levels

Disagreement in how of levels of prevention (primary, secondary, tertiary) are defined has become a source of confusion among public health practitioners. Different schools of thought argue the appropriateness of terminology. In one school of thought, primary prevention refers to the prevention of a disease – whether that is defined by an acute event or a clinical diagnosis. Secondary prevention efforts then are the actions taken to avoid recurrent events. However, others use "primary prevention" to refer to the prevention of the development of *risk factors* for a disease – not the disease itself.

Regardless of the terminology used, the various levels of prevention and the actions taken are the same. For this report, we use the following definitions of prevention levels:

Health promotion: preventing the development of risk factors. Example: interventions to prevent children from becoming obese, through increasing physical activity and improving dietary habits.

Primary Prevention: controlling the levels of risk factors in order to prevent the first occurrence of an event. Example: Among people diagnosed with hypertension, interventions to support the control of high blood pressure in order to reduce risk of a stroke.

Secondary Prevention: early diagnosis of disease, in order to prevent future or recurrent events. Utilizing screening for disease as a method to get to early diagnosis. Preventing future events by intervening on the disease as well as the contributing factors to the disease. That includes treating heart disease with surgical interventions, but also treating hypertension, diabetes, and dyslipidemia.

Tertiary prevention: Including the efforts to prevent recurrence of an event, this is level of prevention is focused on rehabilitation, in order to reduce the severity of disability from an event. Example: Interventions to prevent a second heart attack from occurring in those who have experienced a heart attack, such as ensuring post-discharge disease management occurs.

Table 2 provides examples types of activities relevant towards each of the areas of prevention.

Table 2. General activities for various levels of heart disease and stroke prevention.

Health promotion
Educating the public on the risk factors for heart disease and stroke
Instituting programs to increase physical activity for kids
Establishing policies to help people eat better so they don't become fat or get high cholesterol
Conducting mass social marketing campaigns so people don't start smoking
Developing policies to support the increase physical activity, improve diet and eating habits,
Primary prevention
For those who are overweight or obese, to help them lose weight so they lower their risk of an event
For those who have diabetes, helping them control their diabetes so they lower their risk of developing heart disease or having a stroke
Screening for hypertension or dyslipidemia in the general population (so you can treat it and prevent a heart attack or stroke)
For those who are already diagnosed with hypertension, helping them to control it
For those who are already diagnosed with dyslipidemia, helping them to control it
Conducting social marketing campaigns to get people to stop smoking if they are current smokers
Secondary prevention
Population 1: Undiagnosed for heart disease or stroke Screening for heart disease (which means doing clinical exams and procedures, so you can diagnose it early)
Population 2: Clinically diagnosed with heart disease or stroke (whether or not acute event has occurred) Ensuring that guidelines for care of heart disease patients are followed (so they don't have another event)
Increasing quality of care (for those who have not had an event but are diagnosed with clinical disease, that they get the care they need to avoid an acute event)
Increasing knowledge of the signs and symptoms of a heart attack or a stroke, and the need to call 9-1-1 (so that people can get care faster, thus minimizing the effect of the event, and thus maximizing the rate of recovery and minimizing the level of severity or the risk of sudden death)
Improving emergency response (again to reduce the time to getting appropriate care)
Tertiary prevention
Ensuring that people who have heart disease aren't disabled from it, through rehabilitation
Ensuring that people who have had a stroke aren't disabled from it, through rehabilitation
Increasing quality of care (to ensure that a person having a heart attack or stroke does not die from it suddenly, and that damage due to the event is minimized, and that recovery after the event is maximized)

Relevance of Prevention Levels

Why is a discussion of "prevention levels" relevant in a report on policy development? It is important to distinguish the target populations from one another, and the methods used to reach those populations, because areas of focus differ between organizations and agencies – and policy agendas may accordingly differ. This discussion of prevention levels is relevant to the state heart disease and stroke prevention programs because of the priorities that we are asked to focus on in our cooperative agreement with CDC. Not only should we be involved with the *development of policies* that impact heart disease and stroke, we are asked to focus efforts on the development of policies which are *specific to secondary and tertiary prevention*.

This is not to say that policies intended to address secondary prevention (or tertiary prevention) do not also have implications for primary prevention. For example, policies centered on increasing control of blood pressure in diagnosed hypertensives may involve requiring improvements in the health care delivery system. These improvements could include addressing ways to remind and counsel patients to exercise and eat a healthier diet, regardless of their disease or risk factor status.

Policies which are directly relevant in a primary prevention setting also may have implications on for secondary prevention. For example, advocating for sidewalks to be incorporated into new residential developments supports physical activity and exercise. Physical activity is a health behavior that impacts the development of risk factors (obesity, diabetes, abnormal cholesterol, high blood pressure, etc.), and as such could be labeled as a primary prevention activity. However, physical activity is a health behavior that is recommended for the control of risk factors (high blood pressure, abnormal cholesterol) – thus it can also be labeled as a secondary prevention strategy.

Heart disease and stroke, like all chronic diseases, are multi-faceted in nature – that is, they have several etiologic factors. As such, they are impacted significantly in the population by taking a multi-pronged approach. High blood pressure, high cholesterol, cigarette smoking, diabetes, obesity, and physical inactivity are some of the many factors which increase risk for heart disease and stroke.

There are many intervention points along the continuum of disease which can be addressed: primary prevention efforts can prevent the development of risk factors, secondary prevention efforts can prevent the development of disease even in the presence of risk factors, and tertiary prevention efforts can prevent the recurrence of a cardiac event or stroke, and further disability or complications after a cardiac event or stroke.

Policies can and do impact the burden of heart disease or stroke at different points in the natural history of these diseases. Currently, most health-related public policies are focused on the area of tobacco and cigarette smoking. Arguably, this is a primary prevention approach – but it also affects secondary and tertiary prevention of heart disease and stroke.

Prevention Priorities of the Minnesota Heart Disease and Stroke Prevention Unit

The Minnesota Heart Disease and Stroke Prevention Unit is partnering with other categorical programs to address *primary prevention* of heart disease and stroke in the population. These primary prevention efforts focus on physical inactivity, poor nutrition and diet, tobacco use, obesity, and diabetes.

In 2003, the Centers for Disease Control and Prevention Division of Heart Disease and Stroke Prevention announced a focus on *"secondary prevention"* of heart disease and stroke. Moreover, priority areas for the heart disease of stroke were established. They include the following:

- Control of High Blood Pressure
- Control of High Cholesterol
- Know Signs and Symptoms; Call 9-1-1
- Improve Emergency Response
- Improve Quality of Care
- Eliminate Disparities

Accordingly, the current focus of the Minnesota Heart Disease and Stroke Prevention Unit is on these areas. This report and the results in Chapter 2 are focused on the policies related directly to *secondary* prevention of heart disease and stroke and the priority areas stated above.

Chapter 2: Minnesota Policies Related to Heart Disease and Stroke

As of July 2006, seven (7) statutes or other state-level legislative actions in Minnesota were found to be directly relevant towards heart disease and stroke prevention, treatment or control.[2*] Table 3 summarizes these policies, organized by priority area topic.

Table 3. Summary of Minnesota statutes and laws relevant to priority areas.

Topic	Statute Number	Year	Status	Brief Description
Control High Blood Pressure	62J.43	2004	Expires 2006	To improve quality and reduce health care costs, state agencies shall encourage the adoption of best practice guidelines and participation in best practices measurement activities by physicians, other health care providers, and health plan companies. The initial best practices and quality of care measurement criteria developed shall include asthma, diabetes, and at least two other preventive health measures. **Hypertension** and **coronary artery disease** shall be included within one year following availability.
Control High Cholesterol	-	-	-	-
Know Signs and Symptoms; Call 9-1-1	-	-	-	-
Improve Emergency Response	604A.01	1999	Active	Good Samaritan Law **for automated external defibrillators** used by bystanders
	144E.103	1999	Active	Requires for **defibrillators** to be on all emergency vehicles
	403.15	2004	Active	Multiline telephone system 911 requirements.
		2006	Active	Funding allocation for 240 **automated external defibrillators** to be placed in state patrol vehicles ($312,000) over the next three years.
Improve Quality of Care	256B.072	2005	Active	Establishes a performance reporting system for health care providers who provide health care services to public program recipients. The measures used for the performance reporting system for medical groups shall include **hypertension** and **coronary artery disease** and **acute myocardial infarction and heart failure** for inpatient hospitals.
Eliminate Disparities	145.928	2001	Active	Establishment of the **Eliminating Health Disparities Initiative** (EHDI). The health commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities.

Control High Blood Pressure. Minnesota Statute 62J.43 was intended to develop a set of best practices and quality of care measures for patient care on the topics of asthma and diabetes. The

[2] One of these statutes actually expired in 2006, but is included in this inventory nonetheless.

intent was to develop a set of performance measures for hypertension (and coronary artery disease) after the initial topics were addressed. This law expired in 2006.

Control High Cholesterol. No legislation currently addresses this topic.

Know Warning Signs and Symptoms, Call 9-1-1. No legislation currently addresses this topic.

Improve Emergency Response. Four legislative actions address emergency response for heart attack or stroke.

First, Minnesota Statute 604A.01 protects lay users from civil litigation in the use of automated external defibrillators. This "Good Samaritan" law has been active since 1999, and amended in 2002 to expand application to lay persons.

Second, Minnesota Statute 144E.103 requires all ambulances to be equipped with a defibrillator.

Third, Minnesota Statute 403.15 requires all multi-line telephone systems (MLTS) or Private Branch Exchange (PBX) systems in all businesses, multi-unit residential buildings, educational institutions (including schools and colleges), and hotels to be compatible with the existing 911 system. In addition, the law requires all PBX operators to demonstrate or otherwise inform each new telephone system user how to call for emergency assistance from that particular multi-line telephone system. The law's requirements differ for each of the above-listed entities, but the goal is the same – to ensure that emergency responders are able to quickly and safely locate and assist people during medical emergencies, ultimately saving lives.

Fourth, in 2006, the state legislature approved appropriations of $312,000 to fund the purchase and placement of automated external defibrillators in state patrol vehicles. This action was approved upon the promise of 150 additional devices to be purchased and placed by the Mdewakanton Sioux tribal organization. Through this appropriation, all state patrol vehicles serving greater Minnesota will be equipped with an automated external defibrillator.

Improve Quality of Care. Minnesota Statute 256B.072 establishes a system for reporting performance measures, including those related to hypertension control and coronary artery disease. This law was enacted in 2005.

Eliminate Disparities. Minnesota Statute 145.928 establishes the Eliminating Health Disparities Initiative. This program provides grant funding to community-based organizations serving populations of color. Grantee organizations direct regional projects to address target populations on health topics, including cardiovascular disease and stroke.

Complete text of these statutes can be found in Appendix A. In addition, the text for Executive Order 06-10 (signed by Governor Tim Pawlenty on July 31, 2006) is provided. A listing of resources available to conduct database searches for tobacco, physical activity, and nutrition-related policies in Minnesota can be found in Appendix B. Additionally, a listing of some national policies and searchable databases can be found in Appendix C

Chapter 3: Policy Options and Recommendations

Based on the current body of statewide legislation reviewed in this report, recommendations from the Minnesota Heart Disease and Stroke Prevention Plan 2001-2010, and discussions within the Minnesota Heart Disease and Stroke Prevention Steering Committee and the Minnesota Stroke Partnership, the following list includes options and recommendations for policy changes to be considered by partners, advocates, and the Minnesota Heart Disease and Stroke Prevention Unit.

Strategies from the Minnesota Heart Disease and Stroke Prevention Plan 2004-2010 related to public policy changes are listed in Appendix D.

Minnesota Heart Disease and Stroke Stakeholders and Partners

- Establishment of standards for physical education requirements for K-12 education.
- Establishment of standards for nutrition education requirements for K-12 education.
- Establishment of a statewide ban on smoking in all public places, including bars and restaurants.
- Increasing the tax on tobacco products sold in Minnesota.
- Allocation of tobacco settlement funds to fund smoking cessation programs and a comprehensive tobacco control program, including countermarketing.
- Support for a statewide public awareness campaign to raise awareness of heart attack signs and symptoms.
- Support for enforcement of adherence to guidelines in care of high blood pressure by health care providers.
- Support for enforcement of adherence to guidelines in care of high blood cholesterol by health care providers.
- Establishment of a hypertension and cholesterol screening policy and registry for all primary care providers.
- Requiring the inclusion of clinical decision-making tools in the Health Information Technology system currently being developed in Minnesota.
- Establishment of a stroke care system, similar to the state trauma system.
- Support for the development and maintenance of a telestroke network.
- Requirement that health insurance plans provide adequate coverage for cognitive and physical rehabilitation for stroke survivors.
- Increasing funding for emergency medical services regulatory board and the eight emergency medical services regions to place and replace automated external defibrillators (AEDs) in the community, and provide training on AEDs.
- Establishment of health insurance coverage to all Minnesotans.

Conclusions

Heart disease and stroke can be addressed at different points in its natural history. We as a public health community need to take a comprehensive approach:

- By preventing children and adults from becoming obese, being physically inactive, eating poorly, smoking cigarettes, and developing high blood pressure, abnormal cholesterol levels, or diabetes

- For those who do have risk factors for heart disease and stroke, doing what we can to diagnose them early and treat these conditions so they do not go on to experience an acute cardiac event or stroke

- For those who have experienced a cardiac event, stroke, or have otherwise been diagnosed with clinical disease, taking measures to decrease the likelihood of recurrent events and mitigate disability

Through policy change, systems and environments can be modified to support behavioral changes and quality of health care. In the fight to reduce the burden of heart disease and stroke, policy change remains a key and essential strategy.

Please see these CDC resources (find them at: www.cdc.gov/dhdsp) for more guidance on policy development and specific legislation:

- *Taking Action for Heart-healthy and Stroke-free States: A Communication Guide for Policy and Environmental Change, 2004. Centers for Disease Control and Prevention, Atlanta, Georgia.*

- *Guide to the ABCs of State Heart Disease and Stroke Policymaking. Heart Disease and Stroke Prevention Policy Project. October 2006.*

- *Heart Disease and Stroke Prevention Policy Project Annotated Bibliography. Centers for Disease Control and Prevention, Atlanta, Georgia. October 2006.*

Epilogue: Approaching Policy Development

Any discussion of "policy" development should clarify the type of policy, subcategories of policy (or combination of these categories), and areas of focus or level of prevention which are to be addressed. This clarification is essential, because different areas of need should be addressed through appropriate types of policies. In other words, not every heart disease or stroke need should be (nor necessarily can be) addressed through legislation or other public policy.

Different parameters should be considered in the planning stages of policy development. Specifically, these questions should be answered:

- Whose agenda is being pursued? Namely, the state HDSP program, the state coalition, or a specific advocacy or interest group?
- What type of policy should be developed?
- If public policy, what kind of legislation should be written?
- What area of focus should be addressed – a risk behavior, a risk condition, or heart disease/stroke treatment or management?
- What level of prevention is this policy aimed at addressing?
- Who will this policy affect – Which populations, and in what sectors?

These questions can be addressed at any time, but may be helpful to consider in the following order:

1. Whose agenda is being pursued? Who is driving the action?

- State Heart Disease and Stroke Prevention Program staff (state health department)
- Partners outside of state health department (health care providers, American Heart Association, business groups, health insurance companies, advocacy groups, etc.)

2. What type of policy should be used to address this issue?

- Public policy
    - Federal
    - State
    - Local
- Regulatory policy
    - Federal
    - State
- Organizational policy

3. What types of public policy – that is, legislation – should be developed?

- Proclamations
- Research
- Appropriations for state HDSP programs
- Appropriations for specific projects or initiatives
- Requirements or regulations affecting prevention of disease or health care

4. Which risk factor(s), behavior(s) and/or diseases of focus are intended to be addressed? Multiple answers may be relevant.

- Risk behaviors
    - Physical activity/exercise
    - Nutrition and diet habits
    - Tobacco use

- Risk factors
    - Hypertension
    - Dyslipidemia
    - Diabetes
    - Obesity

- Conditions/diseases
    - Heart disease
    - Stroke

Note: This is a relevant variable to consider because if the answer to question 1 is the state HDSP program, then the topic area should be likely be focused on hypertension, dyslipidemia, heart disease, and/or stroke. This is not a hard-and-fast rule, however, because these topics are not necessarily specific only to one level of prevention. Which leads us to the next consideration:

5. What point in the continuum of cardiovascular health and disease will be the target of the policy change? That is, what level of prevention are we going to attempt to act on?

- Health Promotion – prevention of risk factor development
- Primary prevention – screening and control of risk factors
- Secondary prevention – prevention of recurrent events
- Tertiary prevention – rehabilitation and limiting disability

Note: This is a relevant variable to consider because if the answer to question 1 is the state HDSP program, then the policy change ought to be addressing *primary, secondary* or *tertiary* prevention, and *not* health promotion issues (directly).

If it does not neatly fit into the "prevention levels" framework, leave this terminology behind and ask a different question: is this policy relevant to the prevention of risk factors from developing (not the focus of state HDSP programs), or is it relevant to a) the prevention of heart attack or stroke (among those with at least one risk factor, namely hypertension or dyslipidemia), b) increasing the likelihood of survival from a cardiac event or stroke, or c) maximizing the quality and length of life following an cardiac event or stroke?

If the answer to question 1 was "partners external to the state health department," then policy change relevant to *any* of the levels of prevention should be addressed. It should just depend then on the priorities in that state as well as what is already being done (or is on the books).

The rest of these questions should be considered to help shape the policy and its content.

6. What populations will this policy affect?

First, what **setting** will be affected by this policy?

- General community
- Health care
    - Pre-hospital (EMS, dispatch)
    - Emergency departments
    - Hospitals (subacute care)
    - Rehabilitation
    - Outpatient care
    - Insurance/entitlement programs
- Worksites and businesses
- Schools
- Food industry

- Transportation sector
- Land Planning/Development sector
- Governmental agencies
- Other

Note: This is a consideration because most of the interventions that the state health department will focus on will be on emergency medical care, inpatient, and outpatient health care, health insurance and coverage, and worksite issues.

Second, which **populations** will be directly impacted by these policy changes? Arguably, this might be the first issue to be debated – the target population.

- General public
- High-risk population
    - Racial/ethnic group
    - Rural/urban Low income/low education
    - Women
    - Children/youth
    - Elderly
- Professionals and leaders
- Community leaders
- Health care providers
- Health care insurers and payer
- Business owners and management
- Decision makers
    - Legislators
    - Commissioners and other government leaders
    - Executives and business owners
    - School boards, superintendents, principals

Please see *Taking Action for Heart-healthy and Stroke-free States: A Communication Guide for Policy and Environmental Change* for more detailed guidance.

Appendix A. Minnesota Heart Disease and Stroke Prevention Policies

1. Control of High Blood Pressure

62J.43 Best practices and quality improvement.

(a) To improve quality and reduce health care costs, state agencies shall encourage the adoption of best practice guidelines and participation in best practices measurement activities by physicians, other health care providers, and health plan companies. The commissioner of health shall facilitate access to best practice guidelines and quality of care measurement information to providers, purchasers, and consumers by:

(1) identifying and promoting local community-based, physician-designed best practices care across the Minnesota health care system;

(2) disseminating information available to the commissioner on adherence to best practices care by physicians and other health care providers in Minnesota;

(3) educating consumers and purchasers on how to effectively use this information in choosing their providers and in making purchasing decisions; and

(4) making best practices and quality care measurement information available to enrollees and program participants through the Department of Health's Web site. The commissioner may convene an advisory committee to ensure that the Web site is designed to provide user friendly and easy accessibility.

(b) The commissioner of health shall collaborate with a nonprofit Minnesota quality improvement organization specializing in best practices and quality of care measurements to provide best practices criteria and assist in the collection of the data.

(c) The initial best practices and quality of care measurement criteria developed shall include asthma, diabetes, and at least two other preventive health measures. Hypertension and coronary artery disease shall be included within one year following availability.

(d) The commissioners of human services and employee relations may use the data to make decisions about contracts they enter into with health plan companies.

(e) This section does not apply if the best practices guidelines authorize or recommend denial of treatment, food, or fluids necessary to sustain life on the basis of the patient's age or expected length of life or the patient's present or predicted disability, degree of medical dependency, or quality of life.

(f) The commissioner of health, human services, and employee relations shall report to the legislature by January 15, 2005, on the status of best practices and quality of care initiatives, and shall present recommendations to the legislature on any statutory changes needed to increase the effectiveness of these initiatives.

(g) This section expires June 30, 2006.

HIST: 2004 c 288 art 7 s 2

2. Improving Emergency Response

604A.01 Good Samaritan Law.

Subdivision 1. Duty to assist. A person at the scene of an emergency who knows that another person is exposed to or has suffered grave physical harm shall, to the extent that the person can do so without danger or peril to self or others, give reasonable assistance to the exposed person. Reasonable assistance may include obtaining or attempting to obtain aid from law enforcement or medical personnel. A person who violates this subdivision is guilty of a petty misdemeanor.

Subd. 2. General immunity from liability.

(a) A person who, without compensation or the expectation of compensation, renders emergency care, advice, or assistance at the scene of an emergency or during transit to a location where professional medical care can be rendered, is not liable for any civil damages as a result of acts or omissions by that person in rendering the emergency care, advice, or assistance, unless the person acts in a willful and wanton or reckless manner in providing the care, advice, or assistance. This subdivision does not apply to a person rendering emergency care, advice, or assistance during the course of regular employment, and receiving compensation or expecting to receive compensation for rendering the care, advice, or assistance.

(b) For the purposes of this section, the scene of an emergency is an area outside the confines of a hospital or other institution that has hospital facilities, or an office of a person licensed to practice one or more of the healing arts under chapter 147, 147A, 148, 150A, or 153. The scene of an emergency includes areas threatened by or exposed to spillage, seepage, fire, explosion, or other release of hazardous materials, and includes ski areas and trails.

(c) For the purposes of this section, "person" includes a public or private nonprofit volunteer firefighter, volunteer police officer, volunteer ambulance attendant, volunteer first provider of emergency medical services, volunteer ski patroller, and any partnership, corporation, association, or other entity.

(d) For the purposes of this section, "compensation" does not include payments, reimbursement for expenses, or pension benefits paid to members of volunteer organizations.

(e) For purposes of this section, "emergency care" includes providing emergency medical care by using or providing an automatic external defibrillator, unless the person on whom the device is to be used objects; or unless the person is rendering this care during the course of regular employment, the person is receiving or expects to receive compensation for rendering this care, and the usual and regular duties of the person include the provision of emergency medical care. "Automatic external defibrillator" means a medical device heart monitor and defibrillator that:

(1) has received approval of its premarket notification, filed pursuant to United States Code, title 21, section 360(k), from the United States Food and Drug Administration;

(2) is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia, and is capable of determining, without intervention by an operator, whether defibrillation should be performed; and

(3) upon determining that defibrillation should be performed, automatically charges and requests delivery of an electrical impulse to an individual's heart.

HIST: 1994 c 623 art 2 s 1; 1995 c 205 art 2 s 8; 1998 c 329 s 1; 2001 c 107 s 1

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144E.103. General Requirements for equipment on ambulances.

Subdivision 1. General requirements. (a) Every ambulance in service for patient care shall carry, at a minimum:

(1) oxygen;

(2) airway maintenance equipment in various sizes to accommodate all age groups;

(3) splinting equipment in various sizes to accommodate all age groups;

(4) dressings, bandages, and bandaging equipment;

(5) an emergency obstetric kit;

(6) equipment to determine vital signs in various sizes to accommodate all age groups;

(7) a stretcher;

(8) a defibrillator; and

(9) a fire extinguisher.

(b) A basic life support service has until January 1, 2001, to equip each ambulance in service for patient care with a defibrillator.

Subd. 2. Advanced life support requirements. In addition to the requirements in subdivision 1, an ambulance used in providing advanced life support must carry drugs and drug administration equipment and supplies as approved by the licensee's medical director.

Subd. 3. Storage. All equipment carried in an ambulance must be securely stored.

Subd. 4. Safety restraints. An ambulance must be equipped with safety straps for the stretcher and seat belts in the patient compartment for the patient and ambulance personnel.

HIST: 1999 c 245 art 9 s 25

ARTICLE 12
TRANSPORTATION

Section 1. TRANSPORTATION APPROPRIATIONS.

The sums shown in the columns marked "APPROPRIATIONS" are added to the appropriations in Laws 2005, First Special Session chapter 6, article 1, or other specified law, to the named agencies and for the specified purposes. The sums shown are appropriated from the general fund, or another named fund, to be available for the fiscal year indicated for each purpose. The figure "2007" used in this article means that the appropriations listed under it are available for the fiscal year ending June 30, 2007.

	APPROPRIATIONS Available for the Year Ending June 30, 2007
	$
Sec. 2. TOTAL APPROPRIATION	692,000

Sec. 3. TRANSPORTATION

Department of Transportation radio tower 380,000

To design and construct a new radio tower in Roseau County. This appropriation is available until expended.

Sec. 4. STATE PATROL

Automatic defibrillators 312,000

For purchase of automated external defibrillators for State Patrol vehicles. This is a onetime appropriation. It is available until June 30, 2009, and is available only as matched by $2 from nonstate sources for each $3 from this appropriation.

Sec. 5. EFFECTIVE DATE.

This article is effective the day following final enactment.

403.15 Multiline telephone system 911 requirements.

Subdivision 1. Multistation or PBX system. Except as otherwise provided in this section, every owner and operator of a new multistation or private branch exchange (PBX) multiline telephone system purchased after December 31, 2004, shall design and maintain the system to provide a call-back number and emergency response location.

Subd. 2. Multiline telephone system user dialing instructions. Each multiline telephone system operator must demonstrate or otherwise inform each new telephone system user how to call for emergency assistance from that particular multiline telephone system.

Subd. 3. Shared residential multiline telephone system. On and after January 1, 2005, operators of shared multiline telephone systems, whenever installed, serving residential customers shall ensure that the shared multiline telephone system is connected to the public switched network and that 911 calls from the system result in at least one distinctive automatic number identification and automatic location identification for each residential unit, except those requirements do not apply if the residential facility maintains one of the following:

(1) automatic location identification for each respective emergency response location;

(2) the ability to direct emergency responders to the 911 caller's location through an alternative and

adequate means, such as the establishment of a 24-hour private answering point; or
(3) a connection to a switchboard operator, attendant, or other designated on-site individual.

Subd. 4. Hotel or motel multiline telephone system. Operators of hotel and motel multiline telephone systems shall permit the dialing of 911 and shall ensure that 911 calls originating from hotel or motel multiline telephone systems allow the 911 system to clearly identify the address and specific location of the 911 caller.

Subd. 5. Business multiline telephone system. (a) An operator of business multiline telephone systems connected to the public switched telephone network and serving business locations of one employer shall ensure that calls to 911 from any telephone on the system result in one of the following:
(1) automatic location identification for each respective emergency response location;
(2) an ability to direct emergency responders to the 911 caller's location through an alternative and adequate means, such as the establishment of a 24-hour private answering point; or
(3) a connection to a switchboard operator, attendant, or other designated on-site individual.

(b) Except as provided in paragraph (c), providers of multiline telephone systems serving multiple employers' business locations shall ensure that calls to 911 from any telephone result in automatic location identification for the respective emergency response location of each business location sharing the system.

(c) Only one emergency response location is required in the following circumstances:

(1) an employer's workspace is less than 40,000 square feet, located on a single floor and on a single contiguous property;
(2) an employer's workspace is less than 7,000 square feet, located on multiple floors and on a single contiguous property; or
(3) an employer's workspace is a single public entrance, single floor facility on a single contiguous property.

Subd. 6. Schools. A multiline telephone system operated by a public or private educational institution, including a system serving dormitories and other residential customers, is subject to this subdivision and is not subject to subdivision 3. The operator of the education institution
multiline system connected to the public switched network must ensure that calls to 911 from any telephone on the system result in one of the following:
(1) automatic location identification for each respective emergency response location;
(2) an ability to direct emergency responders to the 911 caller's location through an alternative and adequate means, such as the establishment of a 24-hour private answering point; or
(3) a connection to a switchboard operator, attendant, or other designated on-site individual.

Subd. 7. Exemptions. (a) Multiline telephone systems with a single emergency response location are exempt from subdivisions 1 and 3 to 6 and section 403.07, subdivision 3.

(b) Multiline telephone system operators that employ alternative methods of enhanced 911 support are exempt from subdivisions 1 and 3 to 6 and section 403.07, subdivision 3.

(c) A multiline telephone system operator may apply for an exemption from the requirements in this section from the chief officer of each public safety answering point serving that jurisdiction.

Subd. 8. Applicability. The requirements of subdivisions 4, 5, and 6 apply to new multiline telephone systems purchased after December 31, 2004. The requirements of subdivisions 2 and 3 and the exemptions in subdivision 7 apply regardless of when the multiline telephone system was installed.

HIST: 2004 c 282 s 9

3. Improving Quality of Care

256B.072 Performance reporting and quality improvement system.

(a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

(b) The measures used for the performance reporting system for medical groups shall include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may require providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a Web site suitable for this purpose.

HIST: 1Sp2005 c 4 art 8 s 43

4. Eliminating Disparities

145.928 Eliminating health disparities.

Subdivision 1. Goal; establishment. It is the goal of the state, by 2010, to decrease by 50 percent the disparities in infant mortality rates and adult and child immunization rates for American Indians and populations of color, as compared with rates for whites. To do so and to achieve other measurable outcomes, the commissioner of health shall establish a program to close the gap in the health status of American Indians and populations of color as compared with whites in the following priority areas: infant mortality, breast and cervical cancer screening, HIV/AIDS and sexually transmitted infections, adult and child immunizations, cardiovascular disease, diabetes, and accidental injuries and violence.

Subd. 2. State-community partnerships; plan. The commissioner, in partnership with culturally based community organizations; the Indian Affairs Council under section 3.922; the Council on Affairs of Chicano/Latino People under section 3.9223; the Council on Black Minnesotans under section 3.9225; the Council on Asian-Pacific Minnesotans under section 3.9226; community health boards as defined in section 145A.02; and tribal governments, shall develop and implement a comprehensive, coordinated plan to reduce health disparities in the health disparity priority areas identified in subdivision 1.

Subd. 3. Measurable outcomes. The commissioner, in consultation with the community partners listed in subdivision 2, shall establish measurable outcomes to achieve the goal specified in subdivision 1 and to determine the effectiveness of the grants and other activities funded under this section in reducing health disparities in the priority areas identified in subdivision 1. The development of measurable outcomes must be completed before any funds are distributed under this section.

Subd. 4. Statewide assessment. The commissioner shall enhance current data tools to ensure a statewide assessment of the risk behaviors associated with the health disparity priority areas identified in subdivision 1. The statewide assessment must be used to establish a baseline to measure the effect of activities funded under this section. To the extent feasible, the commissioner shall conduct the assessment so that the results may be compared to national data.

Subd. 5. Technical assistance. The commissioner shall provide the necessary expertise to grant applicants to ensure that submitted proposals are likely to be successful in reducing the health disparities identified in subdivision 1. The commissioner shall provide grant recipients with guidance and training on best or most promising strategies to use to reduce the health disparities identified in subdivision 1. The
commissioner shall also assist grant recipients in the development of materials and procedures to evaluate local community activities.

Subd. 6. Process.
The commissioner, in consultation with the community partners listed in subdivision 2, shall develop the criteria and procedures used to allocate grants under this section. In developing the criteria, the commissioner shall establish an administrative cost limit for grant recipients. At the time a grant is awarded, the commissioner must provide a grant recipient with information on the outcomes established according to subdivision 3.
A grant recipient must coordinate its activities to reduce health disparities with other entities receiving funds under this section that are in the grant recipient's service area.

Subd. 7. Community grant program; immunization rates and infant mortality rates.
The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or both of the following priority areas:

decreasing racial and ethnic disparities in infant mortality rates; or increasing adult and child immunization rates in nonwhite racial and ethnic populations.
The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, coordination activities, and development of community supported strategies.
Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, tribal governments, and community clinics. Applicants must submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or both of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3. The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:
(1) is supported by the community the applicant will serve;
(2) is research-based or based on promising strategies;
(3) is designed to complement other related community activities;
(4) utilizes strategies that positively impact both priority areas;
(5) reflects racially and ethnically appropriate approaches; and
(6) will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 8. Community grant program; other health disparities.

(a) The commissioner shall award grants to eligible applicants for local or regional projects and initiatives directed at reducing health disparities in one or more of the following priority areas:

- decreasing racial and ethnic disparities in morbidity and mortality rates from breast and cervical cancer;
- decreasing racial and ethnic disparities in morbidity and mortality rates from HIV/AIDS and sexually transmitted infections;
- decreasing racial and ethnic disparities in morbidity and mortality rates from cardiovascular disease;
- decreasing racial and ethnic disparities in morbidity and mortality rates from diabetes; or
- decreasing racial and ethnic disparities in morbidity and mortality rates from accidental injuries or violence.

(b) The commissioner may award up to 20 percent of the funds available as planning grants. Planning grants must be used to address such areas as community assessment, determining community priority areas, coordination activities, and development of community supported strategies.

(c) Eligible applicants may include, but are not limited to, faith-based organizations, social service organizations, community nonprofit organizations, community health boards, and community clinics. Applicants shall submit proposals to the commissioner. A proposal must specify the strategies to be implemented to address one or more of the priority areas listed in paragraph (a) and must be targeted to achieve the outcomes established according to subdivision 3.

The commissioner shall give priority to applicants who demonstrate that their proposed project or initiative:

- is supported by the community the applicant will serve;
- is research-based or based on promising strategies;
- is designed to complement other related community activities;
- utilizes strategies that positively impact more than one priority area;
- reflects racially and ethnically appropriate approaches; and
- will be implemented through or with community-based organizations that reflect the race or ethnicity of the population to be reached.

Subd. 9. Health of foreign-born persons. (a) The commissioner shall distribute funds to community health boards for health screening and follow-up services for tuberculosis for foreign-born persons. Funds shall be distributed based on the following formula:

$1,500 per foreign-born person with pulmonary tuberculosis in the community health board's service area;
$500 per foreign-born person with extrapulmonary tuberculosis in the community health board's service area;
$500 per month of directly observed therapy provided by the community health board for each uninsured foreign-born person with pulmonary or extrapulmonary tuberculosis; and
$50 per foreign-born person in the community health board's service area.

(b) Payments must be made at the end of each state fiscal year. The amount paid per tuberculosis case, per month of directly observed therapy, and per foreign-born person must be proportionately increased or decreased to fit the actual amount appropriated for that fiscal year.

Subd. 10. Tribal governments. The commissioner shall award grants to American Indian tribal governments for implementation of community interventions to reduce health disparities for the priority areas listed in subdivisions 7 and 8. A community intervention must be targeted to achieve the outcomes established according to subdivision 3. Tribal governments must submit proposals to the commissioner and must demonstrate partnerships with local public health entities. The distribution formula shall be determined by the commissioner, in consultation with the tribal governments.

Subd. 11. Coordination. The commissioner shall coordinate the projects and initiatives funded under this section with other efforts at the local, state, or national level to avoid duplication and promote complementary efforts.

Subd. 12. Evaluation. Using the outcomes established according to subdivision 3, the commissioner shall conduct a biennial evaluation of the community grant programs, community health board activities, and tribal government activities funded under this section. Grant recipients, tribal governments, and community health boards shall cooperate with the commissioner in the evaluation and shall provide the commissioner with the information needed to conduct the evaluation.

Subd. 13. Report. The commissioner shall submit a biennial report to the legislature on the local community projects, tribal government, and community health board prevention activities funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. These reports are due by January 15 of every other year, beginning in the year 2003.

Subd. 14. Supplantation of existing funds. Funds received under this section must be used to develop new programs or expand current programs that reduce health disparities. Funds must not be used to supplant current county or tribal expenditures.

HIST: 1Sp2001 c 9 art 1 s 48; 2002 c 379 art 1 s 113

Executive Order 06-10, State of Minnesota Office of the Governor. July 31, 2006

I, TIM PAWLENTY, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Constitution and the applicable statutes, do hereby issue this Executive Order:

WHEREAS, the quality and cost of health care affects every Minnesota resident; and

WHEREAS, The Midwest Business Group on Health, one of the nation's leading coalitions of private and public employers, estimates that 30 percent of all direct health care expenditures are the result of care that is poor in quality; and

WHEREAS, the Institute of Medicine ("IOM") estimates that between 44,000 and 98,000 Americans – 700 to 1,600 Minnesotans - die each year from preventable medical errors in hospitals; and

WHEREAS, The New England Journal of Medicine published a study in which patients received only 55 percent of the care recommended for their respective health conditions; and

WHEREAS, diabetes in Minnesota costs $2 billion in medical expenses, disability, and lost time on the job and the prevalence of diabetes in Minnesota has increased by nearly 50 percent over the past decade, yet only 6 percent of Minnesotans who are diagnosed with diabetes receive the optimal care for their condition; and

WHEREAS, purchasing health care based primarily on volume cost factors does not provide incentives to improve the quality of health care services provided; and

WHEREAS, QCare – Quality Care and Rewarding Excellence – is a new quality standard program that will be used by the State of Minnesota in its health care purchasing policies to reward top performing providers while saving millions of dollars in health care costs; and

WHEREAS, the QCare program implements quality of care standards, sets aggressive targets for health care providers, makes measures available to the public online, and changes the health care payment system to reward quality rather than quantity; and

WHEREAS, QCare will transform the way healthcare is purchased in Minnesota by shifting focus away from looking solely on the costs charged by providers to the quality of the care provided to patients; and

WHEREAS, improved quality in health care will help save lives, increase the quality of life for people living with chronic illness, and help to keep health care affordable.

NOW, THEREFORE, I hereby order that:

1. As of the effective date of this order, the Commissioner of Human Services and the Commissioner of Employee Relations are directed to adopt and apply the QCare standards and align payments and incentives for all state purchased health care.

2. To the extent permitted by law, the Commissioner of Human Services and the Commissioner of Employee Relations must apply QCare standard to all state purchased health care including, but not limited to, programs such as Medical Assistance, Minnesota Care, and Minnesota Advantage.

3. All future state contracts with health plans and health care providers must include new incentives and requirements for greater reporting of costs and quality of care delivered based on the QCare standard. In addition, these contracts must contain incentives and requirements for meeting targets and goals, for improvements in key areas, and for greater overall accountability for results.

4. Where applicable, a waiver will be sought from federal agencies to allow QCare standards and incentives to be included in any contract with health plans and health care providers for state purchased health care services.

5. The Commissioner of Human Services and the Commissioner of Employee Relations will report to the Governor prior to agreement in principle regarding any state purchased health care to ensure that QCare standards are included, as appropriate, in any such agreement.

Pursuant to Minnesota Statutes 2004, Section 4.035, Subd. 2, this Order shall be effective fifteen (15) days after publication in the State Register and filing with the Secretary of State and shall remain in effect until it is rescinded by proper authority or it expires in accordance with Minnesota Statutes 2004, Section 4.035, Subd. 3.

Appendix B. Minnesota Tobacco, Physical Activity, and Nutrition Policies and Data Sources

Topic: Tobacco

Policy Information

Smoke-free laws and ordinances
http://www.smokefreecoalition.org/issues/secondhandsmoke/facts/index.asp?id=422&di=/issues/secondhandsmoke/facts/

Map of smoke free laws in Minnesota:
http://www.alamn.org/mn/PublicPolicy/LawMap.asp

Tobacco-Free Park and Recreation Policies
http://www.ansrmn.org/tfyr_mn_policies.htm

Resources

Minnesota Smoke-Free Coalition
http://www.smokefreecoalition.org/index.asp

Association for Nonsmokers- Minnesota
http://www.ansrmn.org/default.htm

Tobacco-Free Youth Recreation
http://www.ansrmn.org/TFYR03Home.htm

Topic: School Health – physical and health education; food and physical activity environment

National Association of State Boards of Education

Includes policies and links regarding health education, physical education, nutrition education, and a health-promoting environment (school food services, school food environment, physical activity other than physical education, tobacco use).

Link: http://www.nasbe.org/healthyschools/States/states.asp?Name=Minnesota&Mode=Print

Topic: Nutrition and Healthy Food Access

Minnesota Grown (Minnesota Department of Agriculture)

Directory of products and services from Minnesota growers.

Link: http://www.minnesotagrown.com

Topic: Physical Activity

American Heart Association

This is website addressing physical activity and physical education advocacy in Minnesota.

Link: http://takeactionforhealth.org/

Appendix C. National Policies and Data Sources

Topic: Tobacco

Searchable database for tobacco policies nationwide (state-specific).

http://apps.nccd.cdc.gov/statesystem/

Topic: Physical Activity and Nutrition – for schools and children

1. Transportation Equity Act

The Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU) was enacted August 10, 2005, as Public Law 109-59. TEA-21 authorizes the Federal surface transportation programs for highways, highway safety, and transit for the 5-year period 2005-2009. On July 29, 2005 both the House and the Senate passed the $286.5 billion package.

The bill includes a five-year, $612 million *Safe Routes to School* program to encourage kids to walk and ride bikes to school. Funds are administered to states according to the number of primary and middle school students they have versus the total number of primary and middle school students in the U.S., with a minimum apportionment of one million dollars per state.

Year	Authorization
2005	$54 M
2006	$100 M
2007	$125 M
2008	$150 M
2009	$183 M

Links:
http://www.fhwa.dot.gov/tea21/

http://www.fhwa.dot.gov/safetealu/index.htm

Fact Sheet:
http://www.fhwa.dot.gov/safetealu/factsheets/saferoutes.htm

2. Child Nutrition and WIC Authorization Act of 2004

United States Department of Agriculture Food and Nutrition Service
Link: http://teamnutrition.usda.gov/Healthy/wellnesspolicy.html

3. Nutrition and Physical Legislative Database.

http://apps.nccd.cdc.gov/DNPALeg/index.asp

Centers for Disease Control and Prevention
National Centers for Chronic Disease Division of Nutrition and Physical Activity

Topic: Obesity

Alliance for a Healthier Generation

Link: http://www.healthiergeneration.org/

Topic: Health Care

Centers for Medicare and Medicaid

1. Expanded coverage for cardiac rehabilitation

   https://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=164

2. Diagnostic Related Group Coverage for tPA

   The Centers for Medicare & Medicaid Services has created a new diagnostic code to reimburse hospitals at a higher rate for acute ischemic stroke patients who are treated with clot-busting agents. The new category, known as diagnosis related group (DRG) 559, will reimburse hospitals $11,578 for a patient treated for acute ischemic stroke with a clot-busting drug. Prior to the new DRG code, reimbursement was limited to $4,000 to $6,000. Effective October 1, 2005.

   Federal Register. Vol. 70, No. 155. Friday, August 12, 2005. Rules and Regulations pp. 10-12.

Appendix D. Public policy strategies from the Minnesota Heart Disease and Stroke Prevention Plan 2004-2010

Goal 1, Objective 1: Engage leadership to develop policy and advocate for issues around heart disease and stroke.

- Stimulate legislative action to finance and support heart disease and stroke prevention and treatment related activities in Minnesota.
- Develop land planning and transportation policies that improve cardiovascular health with identified and engaged elected officials, decision-makers, and stakeholders.
- Encourage adoption of state and federal tax benefits for individuals who enroll in health promotion programs, and encourage employees to take advantage of such tax benefits.
- Promote the economic impacts of land planning and transportation policies and facilities, such as trails and parks, to elected officials, decision-makers, and key stakeholders.
- Provide incentives for land planning and transportation processes, designs, and outcomes that promote and enhance healthy active communities.

Goal 1, Objective 2: Identify and leverage resources through collaborations across non-profit, public and private sectors to improve cardiovascular health.

- Identify land development strategies that improve cardiovascular health and disseminate information to elected officials, decision-makers, and stakeholders.

Goal 2: Prevent development of risk factors for heart disease and stroke.

Physical Activity

- Design communities for walking and other forms of active transportation so they support active living by creating policies and facilities for active transportation connections within and between destinations, including schools.
- Integrate opportunities for recreation within land planning policies and facilities, including schools, so that physical activity may be incorporated into daily routines.

Tobacco

- Advocate for the development, implementation, promotion, and enforcement of smoke-free tobacco policies at all public and private facilities.
- Promote and enforce existing policies that discourage the sale and marketing of tobacco products to youth.

Goal 3: Detect and treat risk factors related to heart disease and stroke

- Achieve international drug price parity and focus on helping people with no or inadequate prescription benefits by advocating for national policy change and supporting local initiatives.

Appendix E. Methods

1. Scan of Minnesota statutes and laws.
This assessment was done by searching the state of Minnesota Office of the Revisor website (www.revisor.leg.state.mn.us). All bills, laws, and statutes can be found on this website. A keyword search was conducted using terms found in the Table below.

Table. Keywords used for searching Minnesota statutes and laws, 2005.

Heart	Cerebrovascular	High blood pressure	Emergency Medical Services
Heart Attack	Cardiovascular	Cholesterol	Disparities
Heart Disease	Defibrillator	High cholesterol	
Stroke	Hypertension	High blood cholesterol	

Only statutes which were deemed relevant to the six priority areas (see page 11) were included in the inventory. In order to make sure this scan was complete, a second search was done by topic area. The gateway page to an alphabetical listing of topics is found at http://ros.leg.mn/stix/. Results from this search were crosschecked with the initial keyword search.

Last, these results were compared with a search of the National Conference of State Legislatures website (www.ncsl.org), which provides a database of state legislation since 1998. The listings for Minnesota were compared to findings from the initial scans.

2. Examination of other state-level policies from around the nation

Current laws in other states were examined to find out what public policy related to heart disease and stroke existed elsewhere. An annotated bibliography produced by Mathematica Policy Research (unpublished as of July 2006, released in September 2006) was reviewed for legislative policy-related examples and information resources. From this list, a variety of sources were reviewed, including the American Heart Association and the National Conference of State Legislatures. A searchable database of these policies is available September 2006. As such, these policies are not specifically presented in this report.

Appendix F. Bibliography

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Policy and Environmental Change: New Directions for Public Health. Association of State and Territorial Directors of Health Promotion and Public Health Education and US Centers for Disease Control and Prevention. Final Report. August 2001.

Taking Action for Heart-healthy and Stroke-free States: A Communication Guide for Policy and Environmental Change. 2004. Centers for Disease Control and Prevention, Atlanta, Georgia.

Heart Disease and Stroke Public Policy in Minnesota. Minnesota Heart Disease and Stroke Prevention Unit, Minnesota Department of Health, December 2006.

Submitted to:

- Minnesota Department of Health, Minnesota Heart Disease and Stroke Prevention Unit
- Minnesota Heart Disease and Stroke Prevention Steering Committee
- Minnesota Stroke Partnership Steering Committee
- Cardiovascular Health Council, National Association of Chronic Disease Directors
- Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention

Contact Information:
Minnesota Heart Disease and Stroke Prevention Unit
Minnesota Department of Health
85 East 7th Place, Suite 400
St. Paul, MN 55101
(651) 201-5412
www.health.state.mn.us/cvh

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