

TAKE HEART ALASKA HEART DISEASE AND STROKE PREVENTION PLAN 2020-2025



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Introduction + Background

Development of the Strategic Plan

This plan was developed by members of the Take Heart Alaska coalition, with leadership from the Steering Committee and assistance from a local contractor, Agnew::Beck Consulting. The Alaska Division of Public Health’s Section of Chronic Disease Prevention and Health Promotion received a grant from the Centers for Disease Control and Prevention (CDC) in 2018 to carry out work to prevent and manage diabetes, heart disease, and stroke. The section’s Heart Disease and Stroke Prevention program used part of this funding to develop a statewide heart disease and stroke prevention plan. The plan’s vision, mission, guiding principles, goals, objectives, and strategies were identified—drawing from members’ expertise, existing data, and evidence-based practices—during multiple coalition working sessions, teleconferences, and online surveys. The coalition approved the final plan in April 2020.

This plan is a living document comprised of four broad goal areas aimed at reducing the burden of heart disease and stroke in Alaska. To meet these aims, it includes specific strategies and objectives to focus on for the next five years. Guided by these goals, strategies, and objectives; specific activities—in the form of annual work plans—have been developed by the three Take Heart Alaska Work Groups:

- (1) Increase Education + Engagement Work Group;
- (2) Promote Early Detection Work Group; and the
- (3) Support Quality Management + Treatment Work Group.

The Take Heart Alaska coalition collaborates with stakeholders and healthcare and community partners to improve cardiovascular health while reducing the overall burden of cardiovascular diseases in their communities. To join the coalition effort or for more details about Work Groups and annual work plans, please reach out to the State of Alaska’s Heart Disease and Stroke Prevention Program at heart@alaska.gov.

Acknowledgments

We wish to acknowledge and thank those who helped create the Take Heart Alaska 2020-2025 Strategic Plan and who continue to work toward a heart disease and stroke free Alaska. Members with an asterisk next to their name are Steering Committee members.

Coalition Members (2019)

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**Steering Committee members.*

Strategic Plan Framework + Coalition Structure

Vision

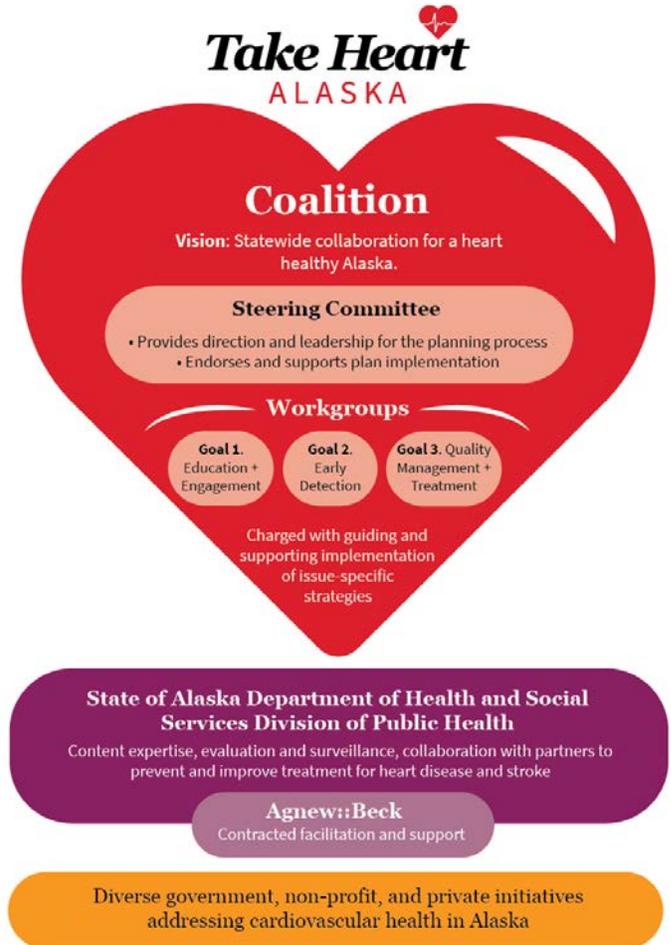
Statewide collaboration for a heart healthy Alaska.

Mission

Take Heart Alaska collaborates with stakeholders and healthcare and community partners to improve cardiovascular health while reducing the overall burden of cardiovascular diseases in their community.

Guiding Principles

- Patient Self-Advocacy + Empowerment
- Collaboration + Partnership
- Health Literacy + Education
- Prevention
- High Value + Quality Healthcare
- Optimum Health for Alaskans



Burden of Heart Disease + Stroke in Alaska¹

What is Heart Disease + Stroke?

The term “heart disease” refers to several different heart conditions including ischemic heart disease (also called coronary artery disease [CAD] or coronary heart disease [CHD]), which can lead to a heart attack, angina, heart failure, and other serious health problems.

Stroke occurs when a blood vessel that feeds the brain either bursts (hemorrhagic stroke) or is blocked (ischemic stroke) causing that part of the brain, and the part of the body it controls, to not work properly.

Why Heart Disease + Stroke are Public Health Concerns?

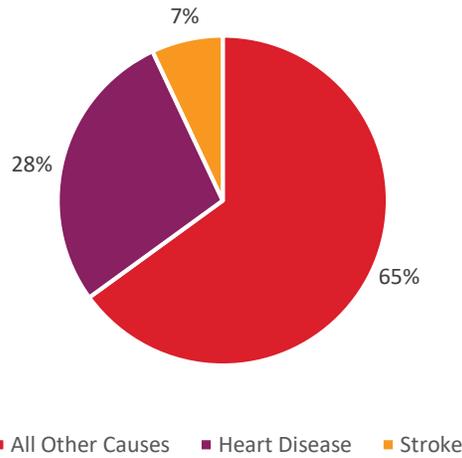
Heart disease and stroke are among Alaska’s leading causes of death and are critical public health priorities. In 2016, heart disease was the second most common cause of death in Alaska and stroke was the fifth (see Table 1). Heart disease and stroke cause about one-third of the deaths in Alaska (see Figure 1). Heart disease is often called the “silent killer” because there are commonly no warning signs or symptoms, and many people do not know they have it.

Table 1: Cause of Death by Rank in Alaska + the U.S. (2016)	Alaska Deaths			US Deaths	
	Number	%	Age-Adjusted Rate	Age Adjusted Rate	Rank
Cause of Death by Rank in Alaska					
1. Cancer	974	22%	152.5	155.8	2
2. Diseases of the Heart	814	18%	136.3	165.5	1
3. Unintentional Injuries	429	9%	61.9	47.4	3
4. Chronic Lower Respiratory Disease	236	5%	40.4	40.6	4
5. Stroke	193	4%	38.2	37.3	5
6. Suicide	186	4%	25.3	13.5	10
7. Chronic Liver Disease and Cirrhosis	123	3%	15.9	10.7	12
8. Diabetes	122	3%	18.6	21.0	7
9. Alzheimer’s Disease	109	2%	25.4	30.3	6
10. Influenza and Pneumonia	60	1%	12.4	13.5	8

Source: Reproduced from State of Alaska, DHSS. Alaska Vital Statistics 2016 Annual Report. Available at http://dhss.alaska.gov/dph/VitalStats/Documents/PDFs/VitalStatistics_AnnualReport_2016.pdf. Accessed 2-17-2020.

¹ Alaska DHSS, Section of Chronic Disease Prevention and Health Promotion Alaska Department of Health and Social Services. *The Burden of Heart Disease and Stroke in Alaska (2019)*. Accessed February 17, 2020: http://dhss.alaska.gov/dph/Chronic/Documents/Cardiovascular/pubs/2019HDSP_BurdenReport.pdf.

Figure 1: Heart Disease + Stroke Contributions to Death Among Alaskans (2007-2016 combined)

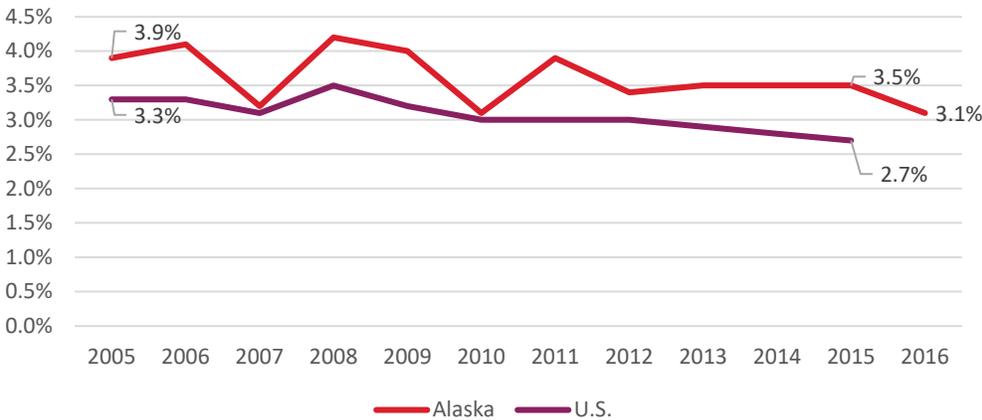


Source: Reproduced from *The Burden of Heart Disease and Stroke in Alaska* (2019) report.

Alaska Heart Disease Prevalence, Mortality + Hospitalization

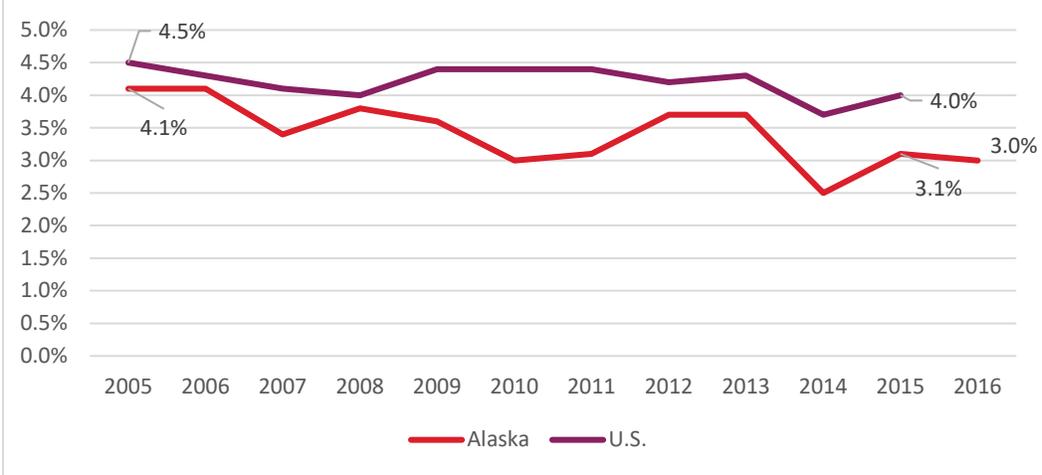
Prevalence in Alaska. According to the most recently available data (2016), 4.3% of adults in Alaska report being diagnosed with heart disease, meaning they have had been diagnosed with a heart attack, coronary heart disease, or both. This translates to more than 24,000 Alaska adults who have been diagnosed with heart disease. The prevalence of heart disease has significantly declined during the past 10 years. This is similar to national trends (see Figures 2 and 3). Note that because heart disease is often asymptomatic and undiagnosed, prevalence rates are based on self-report and are likely underestimated.

Figure 2: Prevalence of Adults Diagnosed with Heart Disease (Heart Attack) in Alaska (2005-2016)



Source: Reproduced from *The Burden of Heart Disease and Stroke in Alaska* (2019) report.

Figure 2: Prevalence of Adults Diagnosed with Heart Disease (Coronary Heart Disease) in Alaska (2005-2016)



Source: Reproduced from *The Burden of Heart Disease and Stroke in Alaska* (2019) report.

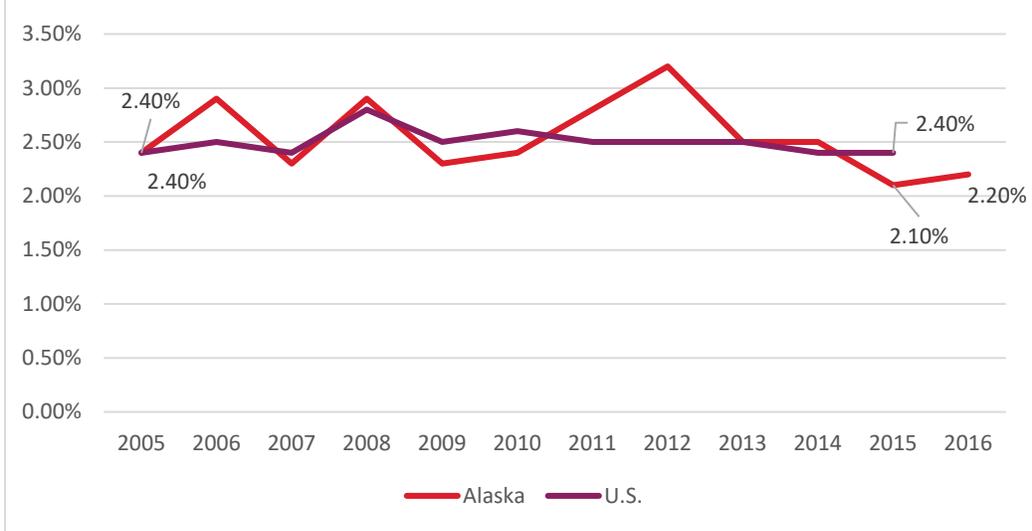
Heart disease-related deaths (mortality). Heart disease is the second leading cause of death in Alaska. It was a cause of death for 21,914 Alaskans between 2007 and 2016. For 7,182 Alaskans, it was the underlying cause of death (i.e., direct cause), and for 14,732 it was a contributing cause of death. Death rates have declined significantly during recent years.

Heart disease-related hospitalizations and outpatient treatment. In total, during 2016, heart disease contributed to 70,782 hospital visits. Of those visits, 12,288 were inpatient visits, where the person was admitted to a hospital. Heart disease was the primary diagnosis (or reason care was needed) for 31% of inpatient visits. The remaining 58,494 cases were outpatient visits (i.e., emergency department, outpatient surgery, outpatient observation, imaging labs, or other services), and for about half of these (51%) heart disease was the primary diagnosis.

Alaska Stroke Prevalence, Mortality + Hospitalization

Prevalence in Alaska. According to 2016 data, 2.2% of adults in Alaska report having had a stroke at some point during their lives. This translates to about 15,000 Alaska adults who have suffered from a stroke. The prevalence of stroke in Alaska has not changed during recent years. Prevalence over recent years has been similar to the U.S. See Figure 3.

Figure 3: Prevalence of Adults Ever Being Diagnosed with Stroke in Alaska + U.S. (2005-2016)



Source: Reproduced from *The Burden of Heart Disease and Stroke in Alaska* (2019) report.

Stroke-related deaths. Stroke is the fifth leading cause of death in Alaska. It was a cause of death for 4,793 Alaskans between 2007 and 2016: 1,720 as the underlying cause of death (i.e., direct cause), and 3,073 as a contributing cause of death. Despite the unchanged stroke prevalence, stroke-related death rates have declined significantly during recent years.

Stroke-related hospitalizations and outpatient treatment. In total, during 2016 strokes contributed to 10,021 hospital visits – 2,725 of these were inpatient visits, where the person was admitted to a hospital, and 7,296 were outpatient visits (i.e., emergency department, outpatient surgery, outpatient observation, imaging labs, or other services). Stroke was the primary diagnosis in about half of cases for each type of visit.

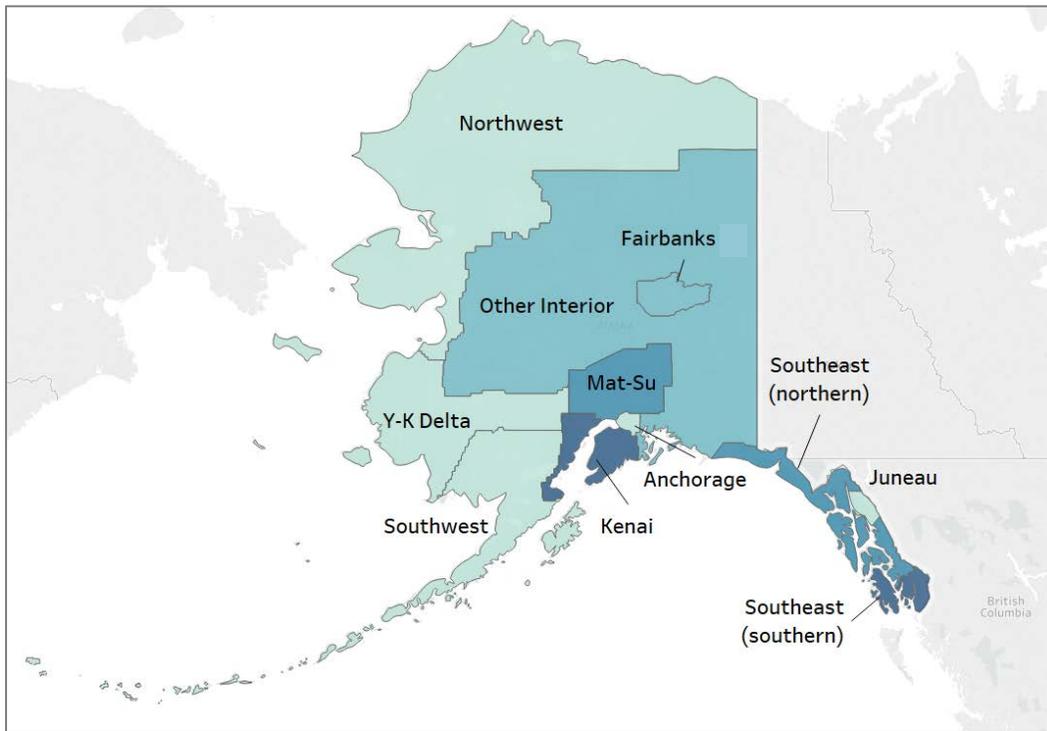
Alaska Heart Disease + Stroke Disparities

Comparisons by race. Despite similar prevalence, both heart disease and stroke-related death and hospitalization rates were higher for Alaska Native people in comparison to Whites. Heart disease-related hospitalization rates were also higher among Pacific Islander people than among Whites.

Other demographic comparisons. Prevalence of heart disease and stroke, as well as related hospitalization and death, increased with age: less than 1% of adults ages 18-44 have heart disease or have had a stroke, compared to 19.0% with heart disease and 11.7% who have had a stroke among adults ages 75 and older. Heart disease and stroke-related hospitalization rates were both higher for men than women. Heart disease prevalence and related death rates were higher for men than women, but stroke prevalence and death rates were similar by gender. Prevalence of heart disease was higher among people with fewer economic resources than among those with more resources.

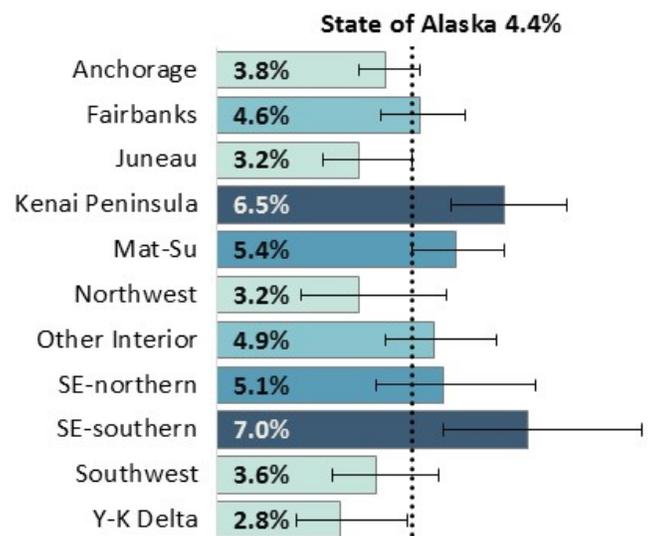
Regional comparisons. The prevalence of heart disease was greater in the Southeast-southern region and Kenai Peninsula region than in the state overall; stroke prevalence was similar across the state's regions. Both heart disease and stroke-related death rates were higher in the Northwest and Yukon-Kuskokwim Delta regions than in the state overall. See Figures 4-6.

**Figure 4: Prevalence of Ever Being Diagnosed with Heart Disease Among Adults by Behavioral Health Systems Region
Alaska, 2012-2016**



*Prevalence of Heart Disease by Behavioral Health Systems Region
Alaska adults, 2012-2016*

	Prevalence	Lower CI	Upper CI
State of Alaska	4.4%	4.1%	4.8%
Anchorage	3.8%	3.2%	4.6%
Fairbanks	4.6%	3.7%	5.6%
Juneau	3.2%	2.4%	4.4%
Kenai Peninsula*	6.5%	5.3%	7.9%
Mat-Su	5.4%	4.4%	6.5%
Northwest	3.2%	1.9%	5.2%
Other Interior	4.9%	3.8%	6.3%
SE-northern	5.1%	3.6%	7.2%
SE-southern*	7.0%	5.1%	9.6%
Southwest	3.6%	2.6%	5.0%
Y-K Delta	2.8%	1.8%	4.3%



Data source: Alaska BRFSS Standard File.

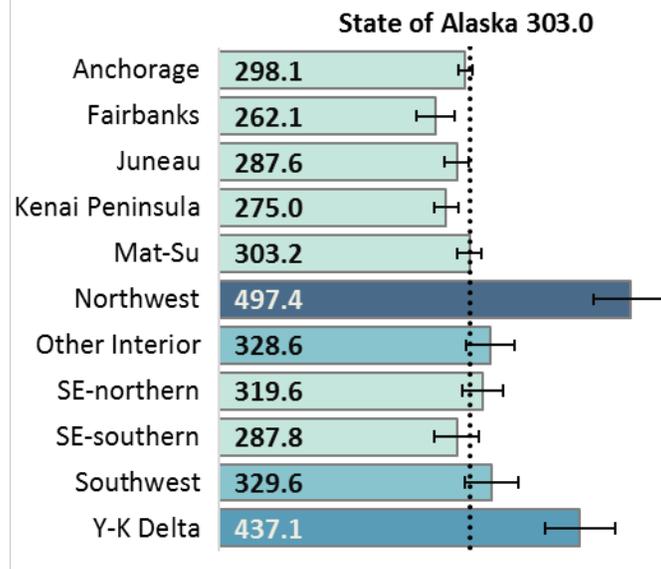
*indicates significant difference between region and state overall.

Figure 5: Heart Disease-related Death Rates Among Adults, by Behavioral Health Systems Region Alaska, 2007-2016, age-adjusted, underlying, and contributing causes of death combined



Heart disease death rate (underlying and contributing causes combined) by Alaska Behavioral Health Systems Region 2007-2016:

	Rate	Lower CI	Upper CI	Count
State of Alaska	303.0	297.7	308.2	14,732
Anchorage	298.1	290.0	306.3	5,807
Fairbanks*	262.1	247.6	276.5	1,509
Juneau	287.6	264.2	311.0	663
Kenai Peninsula*	275.0	260.0	290.0	1,448
Mat-Su	303.2	288.3	318.1	1,876
Northwest*	497.4	452.7	542.2	617
Other Interior	328.6	299.1	358.1	582
SE-northern	319.6	294.9	344.4	682
SE-southern	287.8	260.9	314.6	493
Southwest	329.6	297.6	361.6	548
Y-K Delta*	437.1	395.3	478.8	507



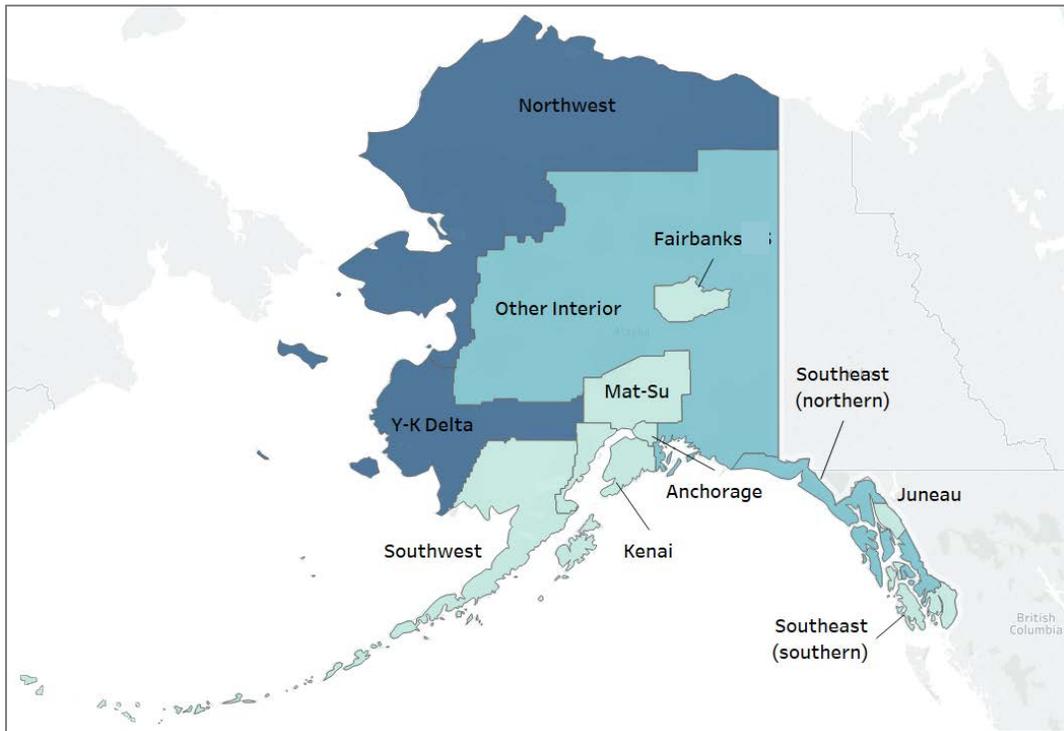
Rates are per 100,000 and age-adjusted to the 2000 U.S.

Standard Population (19 age groups - Census P25-1130).

Source: Alaska Division of Public Health, Health Analytics and Vital Records Section, Mortality Data. Underlying and contributing cause. Only Alaska residents are included.

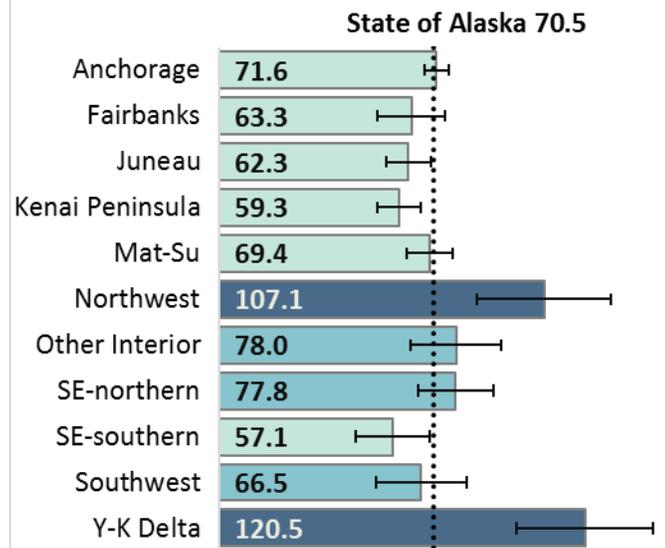
*indicates significant difference between region and state overall.

Figure 6: Stroke-related Death Rates, by Behavioral Health Systems Region
Alaska, 2007-2016, age-adjusted, underlying and contributing causes of death combined



Stroke death rate (underlying and contributing causes) by Behavioral Health Systems Region
Alaska residents, 2007-2016

	Rate	Lower CI	Upper CI	Count
State of Alaska	70.5	67.9	73.1	3,080
Anchorage	71.6	67.5	75.7	1,266
Fairbanks	63.3	55.9	70.7	316
Juneau	62.3	51.1	73.6	130
Kenai Peninsula*	59.3	52.1	66.4	288
Mat-Su	69.4	61.9	76.8	374
Northwest*	107.1	85.1	129.1	110
Other Interior	78.0	63.2	92.9	121
SE-northern	77.8	65.4	90.3	155
SE-southern*	57.1	44.9	69.3	91
Southwest	66.5	51.5	81.6	96
Y-K Delta*	120.5	97.9	143.0	126



Rates are per 100,000 and age-adjusted to the 2000 U.S. Standard Population (19 age groups - Census P25-1130).
Source: Alaska Division of Public Health, Health Analytics and Vital Records Section, Mortality Data. Underlying and contributing causes of death combined. Only Alaska residents are included.
*indicates significant difference between region and state overall.

Screening for hypertension, cholesterol, and diabetes. Most Alaska adults (92%) were current with screening for hypertension, 84% met cholesterol screening recommendations, and 52% have been screened for diabetes in the past three years. Screening rates for all three conditions were lower in the Northwest and Yukon-Kuskokwim Delta regions than in the state overall. Alaska Native adults, rural Alaska residents, and people with fewer economic resources were less likely than the state average to be current with any of the three screenings.

Economic Cost

Hospital stays due to a heart attack or other outcome of heart disease or stroke places a burden on individuals, families, and society. The CDC reports that heart disease costs the United States about \$200 billion each year in terms of health care services, medications, and lost productivity.² Heart attacks (\$11.5 billion) and coronary heart disease (\$10.4 billion) are two of the ten most expensive hospital primary discharge diagnoses.

The impact of heart disease and stroke is also costly in Alaska. In fiscal year 2016, Alaska Medicaid recipients with heart disease alone or in combination with other chronic diseases (9,527 people) needed more than \$300 million in health care paid by Medicaid, with an average per-person cost of more than \$34,000.³

Data Gaps

Data gaps. Currently available information about the prevalence of heart disease in Alaska is based on self-report. The true number of people in Alaska suffering from heart disease is likely to be much greater, because heart disease is often undiagnosed. In the future, health information exchanges that include information about clinical outcomes may help to fill this gap.

For more detailed information regarding the overall burden of heart disease and stroke in Alaska, please see the complete [*The Burden of Heart Disease and Stroke in Alaska*](#) (2019) report.

² Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Heart disease fact sheet. Revised August 23, 2017. https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_disease.htm. Accessed February 17, 2020.

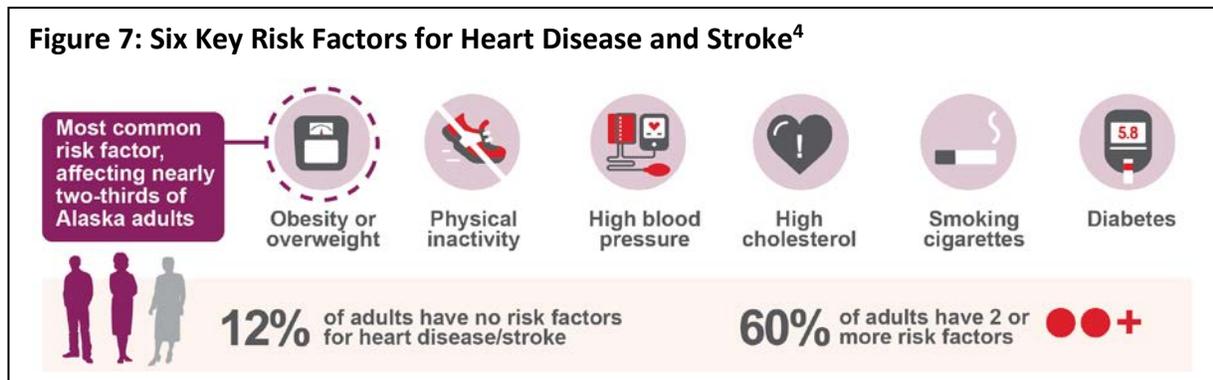
³ Alaska DHSS DPH Section of Chronic Disease Prevention and Health Promotion. Alaska Heart Disease and Stroke Prevention Program website: <http://dhss.alaska.gov/dph/Chronic/Pages/Cardiovascular/default.aspx>. Accessed February 19, 2020.

Solutions to Heart Disease + Stroke

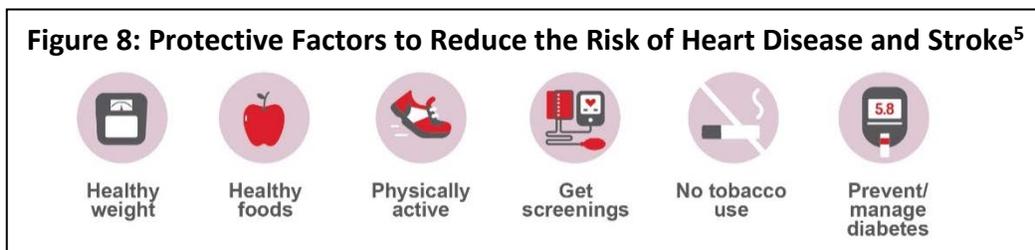
Risk + Protective Factors

There is a growing understanding about the factors that determine the risk of and protectors from heart disease and stroke that make it more or less likely that a person may develop these conditions. Heart disease and stroke share many of the same risk and protective factors, and while some are out of the individual's control (un-modifiable), many can be addressed through lifestyle modifications and/or treatment of related medical conditions.

There are six key risk factors for heart disease and stroke: obesity or overweight, physical inactivity, high blood pressure, high cholesterol, smoking cigarettes, and diabetes. Most Alaska adults (60%) have two or more of them.⁴ Only a small minority of adults (12%) have no risk factors. Having obesity or overweight was the most common risk factor, affecting nearly two-thirds of Alaska adults, followed by physical inactivity, high blood pressure, high cholesterol, smoking cigarettes, and diabetes.



Protective factors, which reduce the risk of heart disease and stroke, include: maintain a healthy weight, eat healthy foods, stay physically active, get blood pressure and cholesterol screenings, no tobacco use, and prevent and/or manage diabetes.⁵ See Figure 8. Risk factors that people are not able to change include: advancing age, male sex, race, family history, and incidence of prior heart events. Although these risk factors cannot be changed, they can give us information and insight needed to prepare for and take precautions against heart disease and stroke.

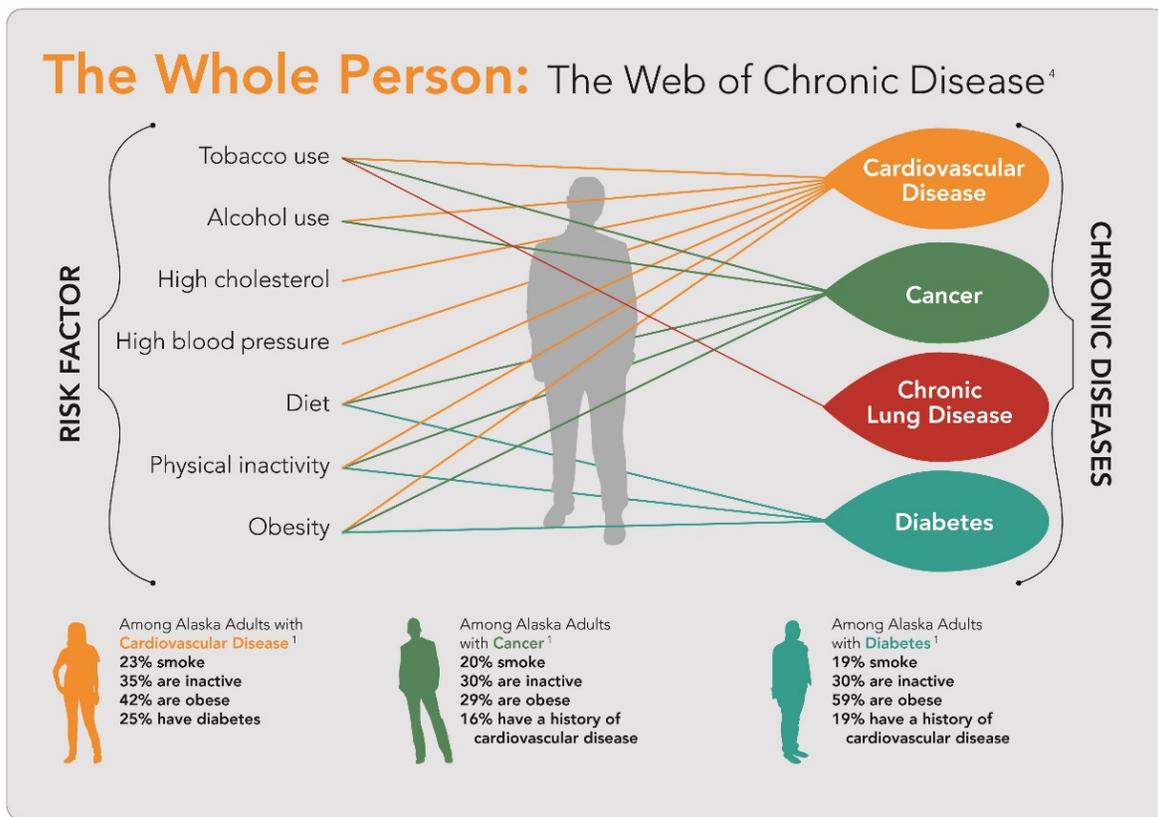


⁴ Alaska BRFSS. Combined data file 2013-2016 for obesity, overweight, smoking and diabetes; Standard data file 2011, 2013, 2015 for physical inactivity and high cholesterol; Standard data file 2011-2015 for high blood pressure.

⁵ Healthy People 2020. Leading modifiable (controllable) risk factors for heart disease and stroke: <https://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke>. Accessed February 18, 2020.

⁶ Remington PL, Brownson RC, Wegner MV, eds. Chronic Disease Epidemiology and Control, 3rd Ed. Washington DC: American Public Health Association, 2010. AK BRFSS (2009-2011). Accessed May 12, 2020: http://dhss.alaska.gov/dph/Chronic/PublishingImages/assets/CDPHP_thewholeperson.gif.

Figure 9: The Web of Chronic Disease⁶



Screening

U.S. Preventive Services Task Force recommendations for screenings related to heart disease and stroke prevention include the following:

- **Blood Pressure:** Ages 18-39: every 3-5 years with BP <120/80 and no risk factors. Check yearly if BP ≥120/80, overweight/obese, African-American, or have diabetes. Over age 39, check yearly.⁷
- **Cholesterol:** Men: Start at age 25 if high risk, repeat every 3 years. If not at high risk, every 5 years, starting at age 35. Women: Start at age 35 if high risk, repeat every 3 years. If not at high risk, every 5 years, starting at age 45.⁸
- **Diabetes:** Blood Sugar/Glucose (diabetes/prediabetes): Start at age 18 if you are overweight/obese and have additional risk factors (e.g. not white, had a baby weighing more than 9 pounds at birth, family history). If normal, repeat every 3 years through age 44. Starting at age 45, every 3 years, but more often if you are overweight or obese, you have high blood pressure or are taking medication for high blood pressure, you exercise fewer than 3 times a week, and/or there are changes in your risk status.⁹

Key Activities to Prevent Heart Disease + Stroke in Alaska¹⁰

The Alaska Department of Health and Social Services and several community partners are diligently working to prevent heart disease- and stroke-related mortality and morbidity. Activities include (but are not limited to):

- Educating and empowering individuals to live healthy lifestyles.
- Supporting healthcare providers and systems to improve screening and management of high blood pressure and ensure optimal treatment of heart disease and stroke.
- Supporting statewide and community partners to promote healthy environments that support physical activity, access to nutritious foods, and smokefree air.

⁷ Final Recommendation Statement: High Blood Pressure in Adults: Screening. U.S. Preventive Services Task Force. September 2017. <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/high-blood-pressure-in-adults-screening>. Accessed February 18, 2020.

⁸ High blood cholesterol levels: Medline Plus Medical Encyclopedia. <https://medlineplus.gov/ency/article/000403.htm>. Accessed February 18, 2020.

⁹ American Diabetes Association. Classification and Diagnosis of Diabetes: Standards of Medical Care in Diabetes – 2018.. Diabetes Care. January 2018. Vol 41, Supplement 1: S13-S27. http://care.diabetesjournals.org/content/diacare/suppl/2017/12/08/41.Supplement_1.DC1/DC_41_S1_Combined.pdf. Accessed February 18, 2020.

¹⁰ Alaska DHSS, Section of Chronic Disease Prevention and Health Promotion Alaska Department of Health and Social Services. *The Burden of Heart Disease and Stroke in Alaska (2019)*. Accessed February 17, 2020: http://dhss.alaska.gov/dph/Chronic/Documents/Cardiovascular/pubs/2019HDSP_BurdenReport.pdf.

Health Equity

Attaining health equity and eliminating health disparities are important goals for achieving optimal health for all Alaskans. Achieving health equity requires addressing unjust health disparities through the modifiable social and economic conditions that policies can shape. These conditions include

- education;
- income;
- geographic location;
- poverty;
- housing;
- discrimination due to sex, race, culture, or other social grouping;
- access to safe places to play and be active;
- the availability of transportation, good schools, tobacco-free environments, and nutritious food.

Health equity is aligned with the acknowledgement and respect of diversity within a community.

The social determinants of health (social, economic, physical, environmental, societal, cultural, and psychological conditions) can affect health outcomes. In Alaska, we have health disparities related to these circumstances. Here are some examples of cardiovascular disease-related disparities in Alaska:

- Men have a higher heart disease mortality rate than women.
- American Indian/Alaska Native (AI/AN) men have the highest mortality rate due to heart disease and heart failure compared to other racial groups.
- AI/AN and Asian/Pacific Islander men have higher rates of stroke mortality than other racial groups.
- AI/AN and rural Alaskans are more likely to not have had a cholesterol screening in the past five years compared to other racial groups.
- Cholesterol screening within five years increases with age, income, and education.
- Percentage with high blood pressure increases with age and lower incomes.
- Alaskans with limited resources are less likely to have had their cholesterol screened and more likely to have high blood pressure.

To achieve optimal health for Alaskans, the goals, objectives, and strategies outlined in this plan will both increase opportunities and support activities that promote health equity and respect for diversity. Identifying ways to modify proposed projects to ensure they will increase health equity and reduce health disparities and how to better understand the uneven impacts on various populations, while difficult undertakings, can be accomplished by including affected populations in the beginning of the dialogue.

Strategic Plan Goals, Strategies + Objectives

Increase Education + Engagement

Strategy: Develop and promote heart disease and stroke prevention messaging specific to target populations.

- **Objective 1:** Increase awareness of and engagement with the Take Heart Alaska coalition.
- **Objective 2:** Increase awareness of and engagement with heart disease and stroke prevention.

Promote Early Detection (of cardiovascular disease)

Strategy: Improve information sharing and referral systems (EHR) to align with standardized screening methods to increase access to evidence-based, cost-effective screening for high blood pressure and cholesterol.

- **Objective 1:** Increase screening opportunities to identify patients with uncontrolled blood pressure/cholesterol and ensure adequate referral.
- **Objective 2:** Increase number of hypertensive/ hypercholesterolemia patients receiving adequate treatment.

Support Quality Management + Treatment

Strategy: Support the implementation of evidence-based management and treatment protocols of heart disease and stroke using the most effective and quality care.

- **Objective 1:** Increase the use of Evidence-Based Practices (EBP) for treatment.
- **Objective 2:** Increase the number of types of providers who deliver management and treatment of heart disease and stroke according to evidence-based protocols.

Strengthen Statewide + Community Partnerships

Strategy: Broaden and strengthen coalition membership.

This strategy will be embedded in the work of each of the strategies above. The goal will be to maintain an active, committed coalition of partners working together to efficiently and effectively achieve our shared vision. We will be building a diverse statewide membership of subject matter experts, healthcare professionals and individuals who are passionate about our mission. We will also maintain a focused, strategic annual action plan for the coalition to focus its implementation work.

Performance Indicators

The purpose of performance indicators is to measure and monitor the coalition’s progress toward achieving our goals. The coalition has identified high-level measures to track overall outcomes (see below), as well as one or more measures for each strategy that the group is currently focused on. Please reach out to the State of Alaska’s Heart Disease + Stroke Prevention Program at heart@alaska.gov for more information on strategy-level indicators.

Overall Heart Disease + Stroke Indicators (Alaska)	Baseline (Date)	Target (2025)	Data Source
Prevalence of Heart Disease (Cardiovascular Disease)	4.4% (2017)	4.2%	BRFSS
Heart Disease-Related Deaths – Age Adjusted	130.4/100,000 (2018)	120/100,000	HAVRS
Prevalence of Stroke	2.3% (2017)	2.2%	BRFSS
Stroke-Related Deaths (Cerebrovascular Diseases) – Age Adjusted	40.4/100,000 (2018)	35/100,000	HAVRS

Sources: Alaska Behavioral Risk Factor Surveillance Survey; Alaska Division of Public Health, Vital Statistics, Mortality.

Reference: Relevant Healthy Alaskans 2030 Indicators

None of the 30 health objectives for [Healthy Alaskans 2030](#) specifically addresses heart disease and stroke prevention directly. However, **three indicators address leading modifiable risk factors** for preventing heart disease and stroke and **three address access to healthcare**, which may indirectly impact heart disease and stroke rates and related risk and protective factors.

- **Indicator 5:** Reduce the percentage of adults (aged 18 years and older) reporting that they could not afford to see a doctor in the last 12 months.
- **Indicator 6:** Reduce the rate of preventable hospitalizations per 1,000 adults (hospitalizations that could have been prevented with high quality primary and preventive care) based on the Agency for Healthcare Research and Quality (AHRQ) definition.¹¹
- **Indicator 8:** Reduce the percentage of the population without health insurance.
- **Indicator 9:** Increase the percentage of children (grades K-8) who meet criteria for healthy weight.
- **Indicator 15:** Reduce the percentage of 3-year-olds who drink any sugary drinks on a given day.
- **Indicator 16:** Increase the percentage of adolescents who meet the Physical Activity Guidelines for Americans (2008 US DHHS Physical Activity Guidelines: adolescents who do at least 60 minutes of physical activity a day, every day of the week)

¹¹ AHRQ Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions. Rockville, MD: Agency for Healthcare Research and Quality, 2001. AHRQ Pub. No. 02-R0203. <https://www.ahrq.gov/downloads/pub/ahrqqi/pqguide.pdf>. Accessed February 17, 2020.

**TAKE HEART ALASKA
HEART DISEASE AND STROKE PREVENTION PLAN
2020-2025**

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