SOCIETY FOR PUBLIC HEALTH EDUCATION
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18 June 2010

The Honorable Kathleen Sebelius
Secretary
US Department of Health and Human Services
200 Independence Ave, SW
Washington, DC

RE: COMMENTS ON A STRATEGIC FRAMEWORK 2010-2015 OPTIMUM HEALTH AND QUALITY OF LIFE FOR INDIVIDUALS WITH CHRONIC CONDITIONS

Dear Secretary Sebelius:

The Society for Public Health Education (SOPHE) applauds efforts of the US DHHS Interagency Workgroup on Multiple Chronic Conditions, led by the U.S. Department of Health and Human Services, to address optimum health and quality of life for individuals with multiple chronic conditions (MCC). As a professional society of some 4,000 national and chapter members, SOPHE has been a longtime national champion for an integrated approach to addressing chronic diseases and improving the quality of life for all persons, particularly those experiencing health disparities.

Overall, SOPHE supports the proposed DHHS framework and the four broad goals as priorities for intergovernmental focus and budgetary allocation for the next five years. ***We strongly urge DHHS to designate the Interagency Task Force as a central priority and allocate resources to support the continued engagement, communication, and accountability of all DHHS agencies involved in this effort.*** DHHS' leadership and commitment are vital to the long-term success of addressing this health and economic epidemic confronting our nation.

To accomplish the goals, SOPHE recommends refinements or expansions in the overall wording of the goal statements as well as their structure and specific objectives. ***We strongly urge the Task Force to incorporate recommendations related to the role of health education specialists; to encourage MCC prevention through comprehensive health and physical education in schools for youth; and to support a nationwide effort to achieve health literacy in all populations.***

SOPHE offers comments under two major areas: 1) Structural comments focus on overall themes within the Framework; 2) Comments on contents offer guidance on specific areas in the document that can use further definition or revision.

I. <u>Structural Guidance</u>

A.1 Creating "SMART" Objectives

Program success is built on objectives that are specific, measurable, appropriate, realistic, and timely (SMART). SOPHE recommends re-examining all proposed objectives to ensure such levels of specificity and accountability. We suggest further examination of the proposed objectives, taking into consideration all SMART criteria, as well as clearly specifying which stakeholders should be accountable or involved in the process.

B.1 Creating Ownership & Accountability for Actions & Strategies

Throughout the Strategic Framework, it is important to emphasize community capacity building and sustainability. Many persons with MCC, especially minorities and low-income populations, have time-limited interactions with healthcare providers and facilities. However, their ultimate ability to properly manage their MCC revolves around the provision of supportive home and community environments. Additional information is needed in the Strategic Plan Framework, highlighting a clear and concise implementation approach for community involvement and support throughout all the goal areas.

C.1 Consideration of Health Literacy/Readability

To remain consistent with the vision of health equity through the provision of national, community and local programming and partnerships, SOPHE strongly recommends that this Framework improve its readability by recognizing that vulnerable populations such as those afflicted by a chronic mental or physical conditions (including the elderly and low income earners) are likely to have marginal or inadequate health literacy skills (i.e., defined as the ability obtain, process, and understand basic health information and services needed to make appropriate health decision.)

The full economic impact of limited health literacy has yet to be calculated, but estimates range from $106 to $236 billion annually; accounting for future costs, the economic toll of limited health literacy rises to $3.6 trillion. Limited health literacy also is associated with substantial indirect costs such as more chronic illness and disability, lost wages, and a poorer quality of life.

To address this issue, government documents and those of state-regulated industries must to be communicated in plain language that is clear, well organized, linguistically and culturally appropriate, and incorporates other best practices of plain language principles. Moreover, training is needed that improves the health system as well as the ability of all individuals to access, understand, and use health information for informed decision-making.

D.1 Dissemination

SOPHE is among many other professional organizations that utilize professional journals to report research and best practices efforts. A coordinated effort to work with journal editors to focus on MCC issues is important in documenting and promoting successful evaluation metrics for programs and policies that target priority populations. In addition, dissemination of programs, policies and goals via social media could be useful in delivering messages and motivating community action.

II. Content Guidance

Goal 1: Provide better tools and information to health care and social service workers who deliver care to individuals with MCC.
Goal 2: Maximize the use of proven self-care management and other services by individuals with MCC.

SOPHE recommends expanding these goals to specifically include the utilization of health education specialists and behavioral scientists. These professionals study, design, conduct, and evaluate comprehensive, evidence-based approaches for improving the health of all people. Health education activities can take place in a variety of settings such as schools, communities, health care facilities, businesses, universities and government agencies. The profession is recognized by the U.S. Department of Labor in the federal Standard Occupational Classification (SOC) system. Although health education specialists are employed under a range of job titles, (e.g., patient educators, health education teachers, public health educators, health program managers), the commonalities are their unique skills and competencies as health education specialists. Many thoroughly tested health education behavior change and self-management models, such as those published by Kate Lorig (Stanford) and Noreen Clark (University of Michigan) hold promise for widespread adoption among persons with MCC.

Strategy 1.A.3 outlines the need for patient materials to assist with patient education. Consultation and involvement from a health education specialist will maximize these efforts through the creation of culturally and linguistically appropriate information that guides a patient through a change process to improve adherence to recommendations and improves outcomes. Health services cannot be structured in a “one-size-fits-all” mentality. Rather, such services must be guided by the community and be culturally and linguistically appropriate and should minimally include: 1) Identification of service modalities and models which are appropriate and acceptable to the communities served, population densities, and targeted population subgroups; 2) identification and involvement of community resources and cross-system alliances for purposes of integrated (client) support and service delivery; 3) assurance of cultural competence at each level of care within the system; 4) the use of culturally competent indicators, adapted for specific minority cultural values and beliefs; 5) the inclusion of representatives of the minority groups present in the population when planning services; 6) the percentage of clients from the minority groups served by or under direct supervision of culturally competent staff; 7) client satisfaction with services, measured in a culturally competent manner; 8) the availability of adult interpreters/translators for families in need of interpretation or translation during service deliver; and 9) documentation that activities and materials are provided in the proportion of the primary language(s) in the population served.

A greater representation of racial and ethnic minorities in the health workforce can reduce health disparities by improving access to and quality of care among minority populations. Existing federal programs that support the education and training of health professionals – including health education specialists – are woefully under funded and do not provide sufficient incentives for minority students.

Strategy 1.A.4
Tools for health care and other professionals should not only include quantitative, clinical data but also incorporate qualitative data to expand understanding of the experience and challenges patients with MCC face. By using both qualitative and quantitative data, more humane, respectful disease management and treatment programs can occur. High quality, patient-centered care is associated with increased treatment compliance and lowered hospital readmission. Ultimately, when more diverse populations are involved in clinical trials, professionals can be more confident of the desired behavioral and educational outcomes.

Objective B: Enhance Health Professionals training: More emphasis is needed on the contributions of health behavior/social scientists and health education specialists. The incorporation of Health Education and Behavior Change theory into clinical training greatly improves patient outcomes. These theories provide understanding and skill building in individual approaches (e.g. adult learning theory, health beliefs, readiness to change, motivational training).

Goal 3: Foster health care and public health system changes to improve the health of individuals with MCC.

SOPHE recommends that this goal be slightly modified as follows: **"Foster the adaptation and systematic adoption of best practices and models as well as the development of innovative health care, public health, and education changes to improve the health of individuals with MCC."**

Several well-known patient-centered medical systems demonstrate both excellent cost control and patient outcomes. Kaiser Permanente, the Cleveland Clinic, Stanford University, the Mayo Clinic and the Geisinger Health System have been lauded for their ability to coordinate care for patient with MCC. These systems are premised on care coordination that includes health education for the patient and caregivers, as well as access to ongoing disease management tools. Evaluating existing care management models that include patient education; referral to appropriate medical, psychosocial, and community services; and ongoing monitoring will help establish best practices that not only control costs but also improve patient productivity.

SOPHE suggests that Strategy 3.E.2 be modified to read "Develop models for use in the health, health education, and public and community health systems for preventing new chronic conditions among persons with MCC." Health education, especially when combined with community health interventions such as the CDC's Racial and Ethnic Approaches to Community Health (REACH), are very effective at reducing chronic disease burden, particularly among racial and ethnic minorities. As racial and ethnic minorities are disproportionately affected by multiple chronic diseases, special attention should be paid to improving disease management among priority populations.

Moreover, SOPHE urges a new strategy to help ensure our nation's future by breaking down silos to address issues related to health and education issues.

Specifically, DHHS should work with DOE to require that all school districts provide a strong preK-12 health education instructional program, delivered by a qualified teacher workforce. Without intervention, children born today may – for the first time in two centuries – have a shorter life expectancy than their parents (Olshansky, et al. 2005. *NEJM* 352(11): 1138-1145). The unprecedented increase in the prevalence of childhood obesity likely will lead to an unprecedented increase in chronic disease rates, particularly diabetes mellitus, heart disease and cancer.

Specifically, we ask that you address four critical needs:

- Provide strong guidance to ensure that all students will experience a robust health education curriculum designed to address critical health needs such as obesity and to develop a health literate society;
- Require all health education teachers to meet state certification standards;
- Provide professional development opportunities to enhance the quality of health education teaching as health and medical knowledge continues to advance; and
- Establish a grant program to support direct funding of schools committed to positively enhancing their delivery of health education programming.

While some of these items may seem outside the scope of the traditional health purview, to truly impact health outcomes, we must break down the silos between health and education – and address issues such as the social determinants. Multiple studies conducted over more than ten years, including one study by the Government Accountability Office, have demonstrated that health and education achievement are inextricably linked. Compared to high school dropouts, youth who graduate from high school are more likely to have better health and lower medical expenses, are more likely to raise healthier, better educated children; likewise, they are less likely to rely on government health care or other social services or to commit crimes.

Clearly, children and youth – especially those in Title I, high-needs schools – must have access to the prevention, early intervention, and health services that support the needs of the whole student. Strong leadership, coupled with access to health care services and management along with psycho-social services, are critical to supporting effective teaching and classroom management, as well ensuring that all students are mentally and physically ready and able to learn.

Goal 4: Facilitate research to fill knowledge gaps about individuals with MCC

SOPHE applauds this goal and looks forward to working with DHHS on opportunities to build understanding as outlined in the SOPHE/CDC Health Education Research Agenda and the SOPHE/CDC Health Disparities Research Agenda. Moreover, research conducted across the continuum that addresses those with MCC have an emphasis on the social determinants of health and should be expanded beyond clinical research to include population health, translation, and dissemination of research to practice. Attention should be directed to facilitating two-way communication and translation of research and lessons learned between the research and practice communities.

Goal 4, Objective D
SOPHE strongly supports an expanded focus on the root causes of diseases that greatly impact individual, family and community health, such as major determinants of health (e.g. education, housing, safety, career development and job training, and transportation). Health education is not only concerned with improving the health of individuals and their families but also improving the ability of communities to provide safe and supportive environments that promote healthy living across the life stages. We strongly encourage the use of a wider range of measurable indicators to help determine current and future impact of social determinants of health on quality of life.

SOPHE also strongly recommends that this goal and related objectives aim to inform individual and community health-related decision making. The increased complexity of health and social problems of this century call for widespread adoption of a new paradigm in which community collaboration provides the foundation for change. Community partnership and action for social change must be integral components of the wellness enterprise. Throughout the past decade, many evidence-based, systems initiatives have developed community-level infrastructures that have helped to reduce risk factors and achieve important health outcomes. These programs and policies emphasize more participatory and equitable approaches, such as community-based participatory research, that by their very nature engage individuals and communities in identifying both problems and solutions to improve their health. Indeed, programs such as CDC's REACH have clearly demonstrated that through interventions that are community based – not just community placed – we can make progress toward eliminating racial and ethnic health disparities. Moreover, approaches that emanate from community involvement and ownership lead to greater program sustainability over time, thus maximizing community investment and utilization of limited resources to effectuate the greatest positive change in patients with multiple chronic conditions.

SOPHE is a professional health education organization founded in 1950 to promote the health of all people by stimulating research on the theory and practice of health behavior; translating sound science into practice; and supporting high quality standards for professional preparation. SOPHE is the only independent professional organization devoted exclusively to public health education and health promotion. There are currently 20 SOPHE chapters covering 32 states across the country.

Thank you very much for considering SOPHE's comments on this proposed rule. Should you have any questions or concerns, please contact Melissa Schober, Project Director at mschober@sophe.org or 202-408-9804.

Sincerely,
Elaine Auld
M. Elaine Auld, MPH, CHES
Chief Executive Officer