July 15, 2009

The Honorable Henry Waxman
Chairman
Energy and Commerce Committee
Washington, DC 20515

The Honorable Joe Barton
Ranking Member
Energy and Commerce Committee
Washington, DC 20515

Dear Chairman Waxman and Ranking Member Barton:

Thank you for your leadership on behalf of the Tri-Committee’s proposed health reform legislation. The Society for Public Health Education (SOPHE) supports the legislation - particularly the sections on prevention and wellness services (Division C, Title III and Title XXXI). We strongly urge you to include the prevention and wellness services section in the final health reform bill. Yet, we strongly urge you to consider strengthening this important legislation by addressing the following components:

- Including “Health Educators” as a critical component of public health and workforce development
- Including “Health Educators” as a member of the pilot medical home model as well as any future reference to a community health care team.
- Codifying CDC’s Racial and Ethnic Approaches to Community Health US (REACH US) program, which according to the GAO, has demonstrated its effectiveness in reducing health disparities and should be expanded to additional communities. (See attached specific language to insert into the draft health reform bill).

Following are further supporting details for each of these recommendations.

Including Health Educators as a Critical Component of Public Health and Workforce Development

Health Educators are in demand in many public health and health care settings today, particularly in federal, state, and local health departments; community-based organizations; and medical care settings. The occupation of “Health Educator” is recognized as a distinct occupational classification by the Office of Management and Budget’s Standard Occupational Policy Committee. According to the Department of Labor Bureau of Labor Statistics (BLS), more than 62,000 health educators are employed throughout the U.S.; by 2016, that number is projected to grow to 78,000. The BLS Occupational Outlook Handbook 2008-09 predicted that the profession of health educators is expected to “grow by 26 percent, which is much faster than the average for all occupations. Growth will result from the rising cost of health care and the increased recognition of the need for qualified health educators.” Moreover, the Handbook states,

“"In the past, it was thought that anyone could do the job of a health educator and the duties were often given to nurses or other healthcare professionals. However, in recent years, employers have recognized that those trained specifically in health education are better qualified to perform those duties. Therefore, demand for health professionals with a background specifically in health education has increased."

More than 250 colleges and universities provide baccalaureate, masters and/or doctoral degrees in health education. Entry-level positions for Health Educators generally require a bachelor’s degree in health education. Graduate health education programs are often offered under titles such as community health education, school health education, or health promotion and lead to a Master of Arts, Master of Science, Master of Education, or a Master of Public Health degree. Furthermore, many health educators have achieved the designation of certified health education specialists (CHES) by the National Commission for Health Education Credentialing, Inc. A list of the areas of
responsibility, competencies and sub-competencies that guide the professional preparation and employment of health educators is available at www.nche.org.

Based on the reported and growing demand for health educators in the public health and health care settings, SOPHE strongly urges you to include “Health Education” as a list of eligible programs for public health workforce development as defined in Division C, Title II, Subtitle C, Subpart XII, Sec. 340M (b)(1)(B)(i); Sec. 340N (b)(1)(B)(i); and Sec. 765 (b)(1), (b)(4)(1), and (c)(1). As with the other health professions listed in those sections, loan repayment and financial incentives are essential to recruiting and retaining an adequate public health education workforce to assist in chronic care management, disease prevention and health promotion. A diverse and well-trained health education workforce is critical to achieving the anticipated return on investment envisioned through this health reform legislation.

Including Health Educators as a Member of the Pilot Medical Home or Community Health Team

Health educators have the requisite training and experience to play a key role in patient care and coordination. As a member of a medical home or community health care team, health educators will serve as a main interface between patients and multiple health providers (e.g. physicians, nurses, behavioral and mental health providers, social workers, nutritionists and dietitians) for information, education, behavioral modification, and referral to community resources. As such, patients who use medical homes or community health care teams, that include health educators, will have access to professionals with specialized skills in patient navigation and community care coordination, and knowledge of public and private community resources that are critical to self-care management and disease prevention.

SOPHE urges the Committees to include “Health Educators” as a critical component of the medical home or community health team model as defined in Division B, Title III, Section 1302. SOPHE suggests listing Health Educators under the “Definitions” section of both the Patient-Centered and Community-Based Medical Home Models.

There are many ways in which a health educator can serve on the medical home or community health care team, including:

- **Lead coordinator of care** – interfaces with doctors, nurses and other health care team members; oversees interaction with each facet of the community health team model; provides leadership on care program development, implementation and evaluation.
- **Patient navigator** – ensures patient’s rights and needs are being met; utilizes evidenced-based public health practice to ensure positive health outcomes for the patient; for example can assist in coordinating transportation to/from visits, can assist with language access barriers, can assist with nutritional requirements directed by dietitians and nutritionists (including healthy cooking instruction and healthy food choices availability in patient’s community).
- **Community interface** - can assist with larger policy change needed in patient’s community (limited access to health services, food deserts, environmental barriers); can conduct strategic planning; organizes and manages coalitions at federal, state, and local levels to assist in community/policy change; coordinates with local community organizations and agencies; plans and conducts mass media and health communications campaigns to change knowledge, attitudes, behaviors, and norms of target populations and to reinforce messages.
- **Fiscal coordinator** – interfaces with insurers needs and coordinates documentation for patient or providers; ensures that payments/deadlines are fulfilled.
- **Quality manager** – facilitates and collects needed qualitative or quantitative data to determine community/patient health needs; conducts trainings of community health team members based on community health team evaluations to ensure the most efficient and quality care is being served.

These are several examples of the roles that a health educator can fulfill on a given medical home or community health team. These roles will most likely be tailored to reflect the needs specific to the community in which the team is functioning.
Inclusion of REACH Codification Language

The CDC’s Racial and Ethnic Approaches to Community Health (REACH) U.S. program is a long-standing, rigorously evaluated, evidence-based and highly recommended program for addressing health disparities around chronic and other diseases in some of our nation’s most underserved populations. The 2003 GAO report, *Health Care: Approaches to Address Racial and Ethnic Disparities*, identified REACH as one of the nation’s most effective programs in addressing health disparities, underscoring its value. The REACH program, which began with the REACH 2010 initiative in 1999, has now grown to include 40 community-led and community-driven interventions in 21 states throughout the country.

SOPHE is a national partner of the National REACH Coalition and urges you to include the codification of the REACH program in the draft legislation to ensure that this valuable, evidence-based program can continue to fight health disparities around cardiovascular disease, diabetes, breast and cervical cancer, hepatitis B, adult immunization, tuberculosis, asthma, infant mortality and other diseases that greatly impact our racial and ethnic minority communities. Attached to this letter is specific language relevant to the REACH that may be inserted into the draft health reform bill.

Earlier this year, President Obama called attention to community-based programs and health disparities by including increases to the REACH program in his FY 2010 budget request. SOPHE respectfully requests that Congress now do the same by solidifying the REACH model in forthcoming health reform legislation. Members of the Congressional Tri-Caucus have also included REACH codification language in their minority health bill, the Health Equity and Accountability Act of 2009, which is set to be released in the coming weeks.

The Society for Public Health Education (SOPHE) is a non-profit organization that represents more than 4,000 individuals with formal training and/or an interest in health education and health promotion throughout the United States and 25 international countries. SOPHE members work in schools, universities, medical care settings, corporations, voluntary health agencies, international organizations, and federal, state and local government. SOPHE and its members provide leadership to the profession of public health education and contribute to the health of all people and the elimination of disparities through advances in health education theory and research, excellence in professional preparation and practice, and advocacy for public policies conducive to health.

As the leading professional organization for Health Educators and one dedicated to achieving health equity, SOPHE strongly believes that the inclusion of the recommendations outlined above is necessary to help strengthen the current draft legislation. We urge you to include Health Educators in professional development of the public health workforce as well as vital members of the medical home or community health care teams. Furthermore, we urge you to codify the REACH program so that this proven, evidence-based program can continue the work of eliminating health disparities.

Should you have any further questions or comments about Health Educators, the CDC REACH program or SOPHE’s recommendations for health reform, please contact Rachael Dombrowski at rdombrowski@sophe.org

Sincerely,

Kathryn Meier, MPH, CHES  
President

M. Elaine Auld, MPH, CHES  
Chief Executive Officer
GRANTS FOR RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH.

(a) Purpose- It is the purpose of this section to provide for the awarding of grants to assist communities in mobilizing and organizing resources in support of effective and sustainable programs that will reduce or eliminate disparities in health and healthcare experienced by racial and ethnic minority individuals.

(b) Authority To Award Grants- The Secretary, acting through the Centers for Disease Control and Prevention, shall award grants to eligible entities to assist in designing, implementing, and evaluating culturally and linguistically appropriate, science-based and community-driven sustainable strategies to eliminate racial and ethnic health and healthcare disparities.

(c) Eligible Entities- To be eligible to receive a grant under this section, an entity shall--

(1) represent a coalition--

(A) whose principal purpose is to develop and implement interventions to reduce or eliminate a health or healthcare disparity in a targeted racial or ethnic minority group in the community served by the coalition; and

(B) that includes--

(i) members selected from among--

(I) public health departments;

(II) community-based organizations;

(III) university and research organizations;

(IV) American Indian tribal organizations, national American Indian organizations, Indian Health Service, or organizations serving Alaska Natives; and

(V) interested public or private healthcare providers or organizations as deemed appropriate by the Secretary; and

(ii) at least 1 member from a community-based organization that represents the targeted racial or ethnic minority group; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, which shall include--

(A) a description of the targeted racial or ethnic populations in the community to be served under the grant;

(B) a description of at least 1 health disparity that exists in the racial or ethnic targeted populations, including health issues such as infant mortality, breast and cervical cancer screening and management, cardiovascular disease, diabetes, child and adult immunization levels, or other health priority area(s) as designated by the Secretary; and

(C) a demonstration of a proven record of accomplishment of the coalition members in serving and working with the targeted community.

(d) Sustainability- The Secretary shall give priority to an eligible entity under this section if the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the activities for which the grant was awarded, the entity (and each of the participating partners in the coalition represented by the entity) will maintain its expenditures of non-Federal funds for such activities at a level that is not less than the level of such expenditures during the fiscal year immediately preceding the first fiscal year for which the grant is awarded.
(e) Nonduplication- Funds provided through this grant program should supplement, not supplant, existing Federal funding, and the funds should not be used to duplicate the activities of the other health disparity grant programs in this Act.

(f) Technical Assistance- The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other nonfinancial assistance necessary to meet the requirements of this section.

(g) Dissemination- The Secretary shall encourage and enable grantees to share best practices, evaluation results, and reports with communities not affiliated with grantees using the Internet, conferences, and other pertinent information regarding the projects funded by this section, including the outreach efforts of the Office of Minority Health and Health Disparity Elimination and the Centers for Disease Control and Prevention.

(h) Administrative Burdens- The Secretary shall make every effort to minimize duplicative or unnecessary administrative burdens on grantees.

**AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated--

(1) such sums as may be necessary to carry out the Public Health Service Act;