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Affordable Care Act: Opportunities and Challenges for Health Education Specialists

Acknowledgements

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About SOPHE

SOPHE is a 501 (c)(3) professional organization founded in 1950 to provide global leadership to the profession of health education and health promotion and to promote the health of all people by: stimulating research on the theory and practice of health education; supporting high quality performance standards for the practice of health education and health promotion; advocating policy and legislation affecting health education and health promotion; and developing and promoting standards for professional preparation of health education professionals. SOPHE members include nearly 4,000 health education professionals and students at the national and chapter levels and in 25 international countries. SOPHE members work in elementary/secondary schools, universities, voluntary organizations, health care settings, worksites, and local/state/federal government agencies.

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Introduction

As the United States moves forward with health care reform, it is important to understand the role that health education specialists¹ can and should play in both primary prevention and chronic disease management. With the passage of the Affordable Care Act (ACA), the United States will shift toward improving health outcomes and become more “health” rather than “sick” focused. To accomplish that shift, the ACA has called for focus on 1) the challenges and needs of both the public health and clinical workforces² in order to improve quality of care and patient safety and 2) expanding community-based programming to support prevention and health promotion. While professional health education specialists can play a significant role in achieving these goals, the term “Health Educator” appears only once in the entire ACA.³

This paper presents relevant background information on the ACA and highlights the role health education specialists can fill within the context of a transitioning health care system. Exploration of the various care delivery models and methods of reimbursement are examined to encourage the formation of a research and advocacy agenda that promotes the integration, future relevance, and funding of the health education specialist as an essential member of the health care team. Specific actions for SOPHE are enumerated.

Historical Perspective

As the health care landscape in the United States moves rapidly toward reform and new prevention and health promotion funding opportunities present themselves, it is paramount for health education specialists to be an integral part of the health care and public health systems to assure optimal health outcomes for all. The question of what role a health education specialist can and should play within the primary care team has been raised and discussed since the mid-1970’s when health maintenance organizations (HMOs) were in their infancy and corporate wellness programs were

¹ The term “health education specialist” is defined as someone who has met, at a minimum, baccalaureate-level required health education academic preparation qualifications, who serves in a variety of settings, and is able to use appropriate educational strategies and methods to facilitate the development of policies, procedures, interventions, and systems conducive to the health of individuals, groups, and communities. Accessed from the 2011 Joint Committee on Health Education and Promotion Terminology on March 25, 2013 at <http://www.aahperd.org/aahe/proDevelopment/upload/Terminology-Report-2011-final.pdf>. The person may also possess the designation of Certified Health Education Specialist (CHES) or Master Certified Health Education Specialist (MCHES). In the literature there are other terms that appear to be either synonymous or highly overlapping with health education specialist. The other terms include, but are not limited to, “health educator,” “community health educator,” “professional health educator,” and “professional community health educator.”

² American Public Health Association. (2012). *The Affordable Care Act’s Public Health Workforce Provisions: Opportunities and Challenges* (Issue Brief). Washington, DC: Accessed on January 2, 2013 at http://www.apha.org/NR/rdonlyres/461D56BE-4A46-4C9F-9BA4-9535FE370DB7/0/APHAWorkforce2011_updated.pdf

³ Office of the Legislative Counsel for the U.S. House of Representatives. (2010). *Compilation of Patient Protection and Affordable Care Act, as amended through May 1, 2010* (Sec. 4103, p. 480). Washington, DC: U.S. Government Printing Office.

As the healthcare landscape in the United States moves rapidly toward reform, it is paramount for health education specialists to be an integral part of the health care and public health systems.

increasing.⁴⁻⁵ Yet, despite over 40 years of sporadic literature discussing the concept, arguably little has been done to truly implement the concept into practice and policy. New opportunities exist as a result of the ACA for health education specialists to broaden their impact and participate in the various new models of service delivery.⁶

The Affordable Care Act (ACA)

The provisions of the ACA are numerous and overhaul two broad areas of policy change: 1) insurance or payer reform, and 2) system or delivery reform.

On the payer or insurance side, ACA includes provisions that allow more people to be covered by insurance, receive more benefits, and reduce the cost of care. On the system or delivery side, the ACA includes provisions that are designed to improve quality and efficiency of care, ensure a stronger workforce and infrastructure, and provide greater focus on public health prevention including the guarantee of an essential set of benefits. Such benefits comprise 10 categories of health services that must be offered and covered by insurance plans that are certified and offered through insurance exchanges and all state Medicaid plans.⁷

The ACA also established the Prevention and Public Health Fund (PPHF) and Community Transformation Grants, which provides a greater focus on prevention and public health. In addition, improvement in quality and efficiency within health care organizations are to occur through the establishment of Accountable Care Organizations (ACO) and Patient-Centered Medical Homes (PCMH). As a result of the ACA, the Patient-Centered Outcomes Research Institute was established to specifically address the mandates for improvement of quality and efficiency.⁸ All of these models provide emerging opportunities for health education specialists.

Payer Reform: Payment Models

In the traditional model known as “fee for service,” a provider is paid for each service rendered, creating a financial incentive to provide more services rather than better health outcomes. A tenet of both Accountable Care Organizations (ACO) and Patient-Centered Medical Homes (PCMH) is incentivized payment structures that financially reward better performance and positive health outcomes. One such method being adopted is the episode-of-care payment (bundled payments) in which payment will be made in one lump sum for all services related to the specific

⁴ Bodenheimer, T. (2005). Helping patients improve their health-related behaviors: What system changes do we need? *Disease Management*, 8(5), 319-330.

⁵ Marks, R., & Allegrante, J. P. (2005). A review and synthesis of research evidence for self-efficacy-enhancing interventions for reducing chronic disability: Implications for health education practice (part II). *Health Promotion Practice*, 6(148), 148-156.

⁶ American Public Health Association. (2011). The Affordable Care Act's Public Health Workforce Provisions: Opportunities and Challenges (Issue Brief). Washington, DC: Accessed on January 2, 2013 at http://www.apha.org/NR/rdonlyres/461D56BE-4A46-4C9F-9BA4-9535FE370DB7/0/APHAWorkforce2011_updated.pdf

⁷ U.S. Department of Health and Human Services. Glossary of terms: Essential Health Benefits. Accessed on January 2, 2013 at www.healthcare.gov/glossary/e/essential.html

⁸ Lorig, K. (2012). Patient-Centered Care Depends on the Point of View. *Health Education & Behavior*, 39(5):523-525.

New opportunities exist as a result of the ACA for health education specialists to broaden their impact and participate in the various new models of service delivery.

condition of the patient. A variety of bundled payment models are being used and include: a) capitated payment, which is a fixed payment per person, per timeframe regardless of services needed or rendered; b) global fee payment in which there is one combined payment to cover multiple provider services treating a single episode of care; and c) prospective payment, which will pay a predetermined rate per-diem or case based.

Bundled payment methods provide a single payment for all services and all providers through a contractual partnership. This is in contrast to existing fee for service systems where every provider, hospital department, pharmacy and facility bills individually as independent contractors. If a patient’s health status improves, the fee will be considered “profitable,” which in theory provides incentives to improve patient health outcomes.⁹

System Reform: Accountable Care Organizations (ACO)

Although payment reform and lowering of costs is one catalyst for the creation of ACOs, this system reform model goes a step further with a broad goal of complete care coordination across the continuum by involving a full array of providers. ACOs will be held to the same quality measures that exist for Medicare Shared Savings Program with performance metrics covering: 1) patient experience; 2) care coordination and patient safety; 3) preventive health, and 4) caring for at-risk populations. Financial bonuses will be available for an ACO meeting or exceeding the various metrics. Figure 1 below shows the foundation of an ACO with each component located inside the pyramid. Competencies of health education specialists are overlaid on the model, with arrows illustrating how those competencies can fill the requirements of the ACO.

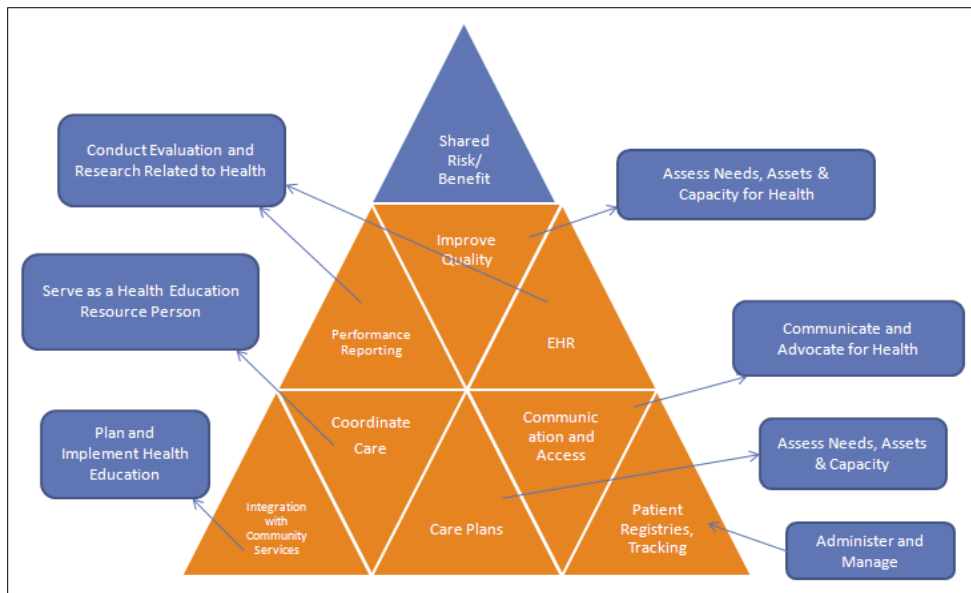


Figure 1: ACO Medical Home in relation to competencies of health education specialists

⁹ Miller, H., D (2011). Transitioning to Accountable Care: Incremental Payment Reforms to Support Higher Quality, More Affordable Health Care. Pittsburgh, PA, Center for Healthcare Quality and Payment Reform.

System Reform: Patient-Centered Medical Home (PCMH)

While the PCMH is not a new idea, within the context of the ACA it has increased importance and prominence. It has the responsibility of care coordination for the patient across all members of the health care team which, in best practice, would be located under one roof. Many chronic diseases, such as HIV care, have been moving toward this concept for some time. Originally put forward in 1967 by the American Academy of Pediatrics with an emphasis on centrally locating a child's medical record, the model has evolved to incorporate several areas of critical importance to the health education specialist. Among the principles of the PCMH¹⁰:

1. Whole person orientation including care for all stages of life and illness including preventative services.
2. Coordinated/integrated care so a person receives what they need where they need it in a culturally and linguistically appropriate manner. This includes better access to care and improved communications both with the patient and among the providers through use of information technologies.
3. Care in which patients actively participate in decision-making and feedback is sought to assure patient expectations are being met.
4. Appropriate reimbursement recognizing the added value of non-physician staff who help coordinate care and improve communications as well as incentivize the achievement of measurable and continuous quality improvements.

ACO & PCMH: Similarities and Differences

There are numerous similarities between the ACO and PCMH. Both are patient-oriented, seek to improve health outcomes, coordinate care, and lower costs through new payment models. However, distinct structural and system differences also exist: 1) ACOs will tend to be larger entities housing many practices within one coordinating and billing entity; 2) an ACO may or may not include a hospital; and 3) patients may seek care outside of the ACO, but the care must be coordinated by the ACO. A PCMH, on the other hand, is a physician-directed medical practice in which the personal physician is responsible for patient coordination. It is envisioned to be a one-stop-shop for all outpatient services.¹¹

Future Opportunities for Health Education

As states moves forward with the ACA and health reform implementation, there are many important roles that health education specialists can play related to health promotion, primary prevention, chronic disease management and primary care. In order to form a comprehensive health care system and improve health outcomes, health education specialists should be integrated into the process of treating the "whole person." Because the new reimbursement and care system is geared toward

¹⁰ Patient-Centered Primary Care Collaborative. (2007). Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home (Updated December 2010). Washington, D.C.

¹¹ Academy Health, Research Insights, Medical Homes and Accountable Care Organizations: If We Build It, Will they Come?, 2010. Accessed at: <http://www.academyhealth.org/files/publications/RschInsightMedHomes.pdf>

If these new models of care are implemented properly, health education specialists have the opportunity to improve the health of all people, enhance the delivery of primary care, and reduce related health care costs.

rewarding health outcomes rather than services rendered, new skill sets will be needed to work with patients as well as providers. Health education specialists possess skills that promote working in interdisciplinary teams, care coordination, quality improvement for strategic planning and systems redesign, community engagement, community needs assessment, and health coaching.^{12,13}

The following are merits for including health education services in cost-effective prevention, wellness and disease management.¹⁴

- Health education improves the health status of individuals, communities, states and the nation. It enhances the quality of life for all people and reduces costly premature deaths and disability.
- By focusing on prevention, health education reduces the costs (both financial and human) spent on medical treatment. Chronic conditions, such as diabetes, heart disease, and cancer, consume more than 75 percent of the \$2.2 trillion spent on health care in the United States each year. This is the equivalent of about 2.5 economic “bailout” packages.¹⁵ Spending as little as \$10 per person on proven preventive interventions could save the country over \$16 billion in just five years.¹⁶
- Health education specialists offer knowledge, skills and training that complement those of health care providers, policy makers, educational experts, human resource personnel and many other professionals whose work impacts human health.
- Addressing a single risk factor (e.g. smoking) influences outcomes across multiple diseases, from preterm birth to lung disease and cancer. Addressing obesity in today's children alters the prevalence of many diseases (e.g. heart disease, cancer, diabetes, arthritis) that may be encountered decades later.

Importance and Relevance of Health Education Specialists

The health education specialist is suited to play an important role in every phase of care and prevention service delivery. The profession has a strong focus on standards and quality assurance vital to having internal and external quality controls over the profession and obtained recognition as a Standard Occupation Classification by the Department of Labor (DOL) in 1997.¹⁷ In 2008, the profession worked with the DOL to update its SOC definition and clarified its distinction from a newly emerging occupational classification for community health workers.

¹² Lorig, K. (2012). Patient-Centered Care Depends on the Point of View. *Health Education & Behavior*. 39(5):523-525.

¹³ Holtrop, J. and Jordan, T. (2010). The Patient-Centered Medical Home and Why it Matters to Health Education. *Health Promotion Practice*, 11(5):622-628.

¹⁴ Sherry, C. (2012). A System's View of the Changing Healthcare Landscape and Health Education's Contribution. Presented at the American Public Health Association Annual Meeting, October 2012.

¹⁵ Partnership to Fight Chronic Disease (2009). January 27, 2009 press release. Access on February 13, 2009 at <http://www.fightchronicdisease.org/media/statements/pfcd/Stimuluspackage.cfm>.

¹⁶ Levi, J., Segal, L. M., & Juliano, C. (2008). *Prevention for a healthier America: Investments in disease prevention yield significant savings, stronger communities*. Trust for America's Health.

¹⁷ Society for Public Health Education. (n.d.). *SOPHE History 1990-1999*. Access on March 23, 2013 from <http://www.sophe.org/sophe/PDF/SOPHE%20History%201990-1999.pdf>

Health education specialists possess skills that promote working in interdisciplinary teams, care coordination, quality improvement, community engagement, community needs assessments, and health coaching.

At the program and professional preparation level, SOPHE published its Statement of Functions of Community Health Educators and Minimum Requirements for their Professional Preparation in 1967. In 1969, the American Public Health Association (APHA) Committee on Professional Education published the first criteria and guidelines for accrediting graduate programs in community health education.¹⁸ Graduation from an accredited school/program is linked to advantages in certain jobs, scholarships, and eventually will be linked to sitting for the CHES/MCHES exams.

Beyond the program level, the health education specialist plays a pivotal role in health care on several other levels noted below with key competencies highlighted for each:

Individual and Family Level

- Health education specialists possess knowledge and skills that can strengthen the physician-directed team and lead to improved patient health outcomes. This includes the ability to coordinate and integrate care, using a more holistic approach to prevention and disease management
- Health education specialists possess skills such as providing self-management support coaching, serving as a bridge to other health care and community resources, helping patients adopt and maintain healthy behaviors, helping families build social and physical environments that support behavior change, assisting patients in navigating the health care system, providing emotional support and providing assistance with practice-level quality. Additionally, health education specialists are trained to deliver health education to individuals and groups.
- Health education specialists employ evidenced-based strategies for health behavior improvement, such as goal setting, action planning, tailored communication, motivational interviewing, and cognitive behavioral techniques. They also support patient partnerships to improve health behaviors both in primary prevention and in reducing complications of chronic diseases.
- Health education specialists apply theories and models of behavior change to improve the health behaviors of individuals and groups. Health education specialists can assist with connecting the clinicians with information and educational resources to meet the challenges patients and their families face in terms of health literacy.
- Health education specialists can play an advocacy role for the family and individual by helping them to evaluate and select a health exchange, complete the enrollment process, and navigate the health system.

Community level

- Health education specialists have an extensive knowledge of communities, including how to connect people to resources, how to

¹⁸Allegante, J.P., Airhihenbuwa, C.O., Auld, M.E., Birch D.A., Roe, K.M., Smith, B.J. (2004), Toward a Unified System of Accreditation for Professional Preparation in Health Education: Final Report of the National Task Force on Accreditation in Health Education. *Health Education & Behavior* 31(6):668-683.

The health education specialist plays a pivotal role in healthcare at the individual, family, community and system levels.

maintain relationships with those resources and how to advocate for patients.

- Health education specialists are trained to be attentive to community needs and can either identify existing materials or develop new materials and strategies that are culturally appropriate.
- Health education specialists are trained to conduct community needs assessments, develop coalitions and build partnerships.
- Health education specialists can help identify and build the bridges between patients and health/medical care organizations that are required to have patient engagement and feedback.

System level

- Health education specialists serve as a resource for other health professionals and may spearhead efforts to evaluate clinical services provided by the health care team.
- Health education specialists are trained to identify a health problem, develop an action plan to resolve that problem and evaluate the success of the intervention.
- Health education specialists receive multi-disciplinary education and training to allow for identification of structural barriers to seeking care and designing culturally competent and patient-centered programs to improve outcomes.

Opportunities within ACO and PCMH

As presented above, the ACA provides new opportunities for health education specialists to complete the health care team working to improve overall care coordination and health promotion activities. Implementation of this health care model also has broader implications for improving the health of racial and ethnic minorities and promoting health equity. As reported by the Commonwealth Fund, a medical home model can reduce or even eliminate racial and ethnic disparities in access to care and quality of care.¹⁹ The health educator represents a vital linkage within that home in order to achieve desired outcomes.

Challenges

Despite the abundance of evidence and literature supporting the role of health education specialists within a primary care environment and their role in improving health outcomes, there are also various challenges that the profession must address in order to make lasting inroads with these new models and funding opportunities. The following paragraphs describe some broad areas that need to be addressed or researched in order to catalyze change.

¹⁹ Beal, A. C. (2007). *Closing the Divide: How Medical Homes Promotes Equity in Health Care*. Commonwealth Fund.

Ambiguity of Job Titles

Anecdotally there is a plethora of job titles and descriptions that have been used in relation to ACA and in new funding opportunity announcements such as patient navigator, patient activator, health coach, patient advocate, community health worker and care coordinator. The ACA requires that each state health insurance exchange establish a navigator program to help individuals and businesses make informed decisions about enrolling in health insurance through the exchange.

Since the first patient navigation program was introduced in 1990 to help reduce disparities in breast cancer care, there has been substantial research and support for patient navigators. The American Medical Association defines the term patient navigator as a role “filled formally or informally by individuals with clinical, legal, financial or administrative experience, or by someone who has personal experience facing health care-related challenges.” Thus, health education specialists could be part of the patient navigation team that focuses on medically underserved populations and promotes a more patient-centric health care service delivery model.

SOPHE and allied organizations, however, should continue their advocacy to increase awareness of the specific competencies and qualifications of health education specialists in comparison to other clinical or lay navigators. Prior research indicates that employers do not fully grasp the range of competencies and skills that a health educator can contribute²⁰. As specified in SOPHE’s strategic plan 2011-2016, SOPHE must help clarify the various job descriptions with employers and stakeholders, and encourage integration of the term “health education specialist” as a professional designation within funding opportunities.

Figure 2 on page 11 provides a crosswalk of competencies among several common job descriptions, and the high degree of overlap and thus inconsistencies in job titles.

Health education specialists can be part of the patient navigation team that focuses on medically underserved populations and promotes a more patient-centric healthcare service delivery model.

²⁰ Hezel Associates, (2007, July). *Marketing the Health Education Profession: Knowledge, Attitudes and Hiring Practices of Employers*. A study commissioned by the Coalition of National Health Education Organizations, American Association for Health Education, National Commission for Health Education Credentialing, Society for Public Health Education, American College Health Association, Eta Sigma Gamma. Accessed March 25, 2013, at [http://www.cnheo.org/PDF%20files/ExecSummary_Marketing%20the%20Health%20Education%20Profession%20\(2\).pdf](http://www.cnheo.org/PDF%20files/ExecSummary_Marketing%20the%20Health%20Education%20Profession%20(2).pdf)

Role/Competency	Title of Profession							
	Health Educator (CHES)	Registered Dietician (RD)	Asthma Educator (AE-C)	Community Health Worker	Patient Navigator	Patient Advocate	Care Coordinator	Health Coach
Assess Needs, Assets and Capacity	X			X				
Comprehensive Planning of Health Education Program	X							
Implement or provide culturally appropriate Health Promotion and Education programming	X	Specific to healthy eating	Specific to asthma	HIV, cancer screening, diabetes, CV, other	Primarily cancer		PCMH	PCMH
• Provide self-management support	X	X	X	X	Emerging		Emerging	X
• Bridge the gap between clinician and patient	X	X	X	X	X		X	X
• Help patients navigate the health care system (includes access to care)	X	X	X	X	X	X	X	X
• Offer emotional support	X	X	X	X	X	X	X	X
• Serve as a continuity figure	X	X	X	X	X		X	X
• Bridge the gap between communities and the health and social service systems	X			X	Emerging		Emerging	
Evaluate and Research	X							
Administer and Manage	X							
Serve as a Resource Person	X	X	X	X		X	X	X
Communicate and Advocate	X			X		X	X	
Reimbursement	Primarily grants	Yes	Yes	Some states or grants	Primarily grants	Own business	Yes, Usually RN or LSW	Yes, if RN or own business

Figure 2: Scope of Practice for Selected Public Health Educators/Workers

Additional Training

Becoming an intrinsic part of a primary care team may require additional clinical knowledge or training. For example, the historic use of the term “patient navigator” within the cancer treatment environment closely parallels the competencies of a health educator with at least one exception of additional clinical knowledge.

Recently SOPHE advocated effectively with major stakeholders in diabetes to formally recognize the role of health education specialists in diabetes prevention and control. In 2012, SOPHE successfully petitioned the American Diabetes Association (ADA) to revise its National Standards for Diabetes Self-Management Education (DSME) to include health educators in the multidisciplinary diabetes team.²¹ The ADA standards are used by certain states and third party insurers to allow for reimbursement for diabetes care and treatment. In 2013, SOPHE also successfully appealed to the National Certification Board of Diabetes Educators to allow Master Certified Health Education Specialists (MCHES) to be eligible to sit for the Certified Diabetes Educator (CDE®) exam.²² In so doing, an individual with MCHES certification can qualify to sit for the exam, provided he/she fulfills NCBDE’s remaining eligibility criteria, including: 1) a minimum of two (2) years, to the day of application, of practice experience as a MCHES; 2) a minimum of 1,000 hours of

²¹ Haas, L., Maryniuk, M., Beck, J., Cox, C.E., Duker, P., Edward, L., Fisher, E., Hanson, L., Kent, D., Kolb, L., McLaughlin, S., Orzeck, E., Piette, J.D., Rhinehart, A.S., Rothman, R., Sklaroff, S., Tomky, D., Youssef G. (2012). National standards for diabetes education and support. *The Diabetes Educator* 38:619

²² Personal communication from Carolyn Harrington, RD, LDN, CDE®, President, National Certification Board of Diabetes Educators to Elaine Auld, CEO, Society for Public Health Education, March 1, 2013.

DSME practice experience in the four years prior to the date of CDE® certification application, 400 hours of which must be in the year immediately prior to application; and 3) a minimum of 15 clock hours of approved continuing education applicable to diabetes, and provided by one of NCBDE's recognized continuing education providers, within two years of the date of application. Upon obtaining the CDE® credential, the health education specialist could obtain a job in a primary care/hospital setting and be reimbursable by third party payers.

Reimbursement Rates

As with the example above of a Diabetes Educator, third party payers generally require some level of licensure and certification. Yet, CHES and MCHES certifications are not recognized by most health insurers. The present fee-for-service system allows for the use of a health education specialist but the services provided by a health education specialist must be ordered by a physician and made part of a treatment plan.²³ Yet, in many situations the cost of health education far exceeds the actual reimbursable rates for this service and must frequently be waived by providers.²⁴ With the rapid movement toward bundled payments, concern exists that such payments may not be calculated to recognize the value a health educator brings to the primary care team. This person must be compensated at appropriate levels commensurate with their training, skills and experience.

Value

Significant literature documents the enormous value that health promotion brings to the health care system and society in general.²⁵ Economic projections show a significant savings that can be achieved by preventing or managing a chronic disease rather than episodic treatment. An important element of the ACA is a directive to the Centers for Disease Control and Prevention to establish an independent Community Preventative Services Task Force, which will focus its efforts on gathering, synthesizing and evaluating sound data upon which policy recommendations can be made.²⁶ SOPHE and other organizations can play a role in recommending individuals to serve on the Task Force, providing studies or literature for consideration, and helping to translate and disseminate its findings.

²³ Auld, M.E. (2012). Health Education's Place at the Table in Health Reform: the Role of Professional Organizations. Presented at the American Public Health Association Annual Meeting, October 2012.

²⁴ Smith, S. A. (1986). Patient education financing under Medicare. *Patient Education and Counseling*, 8(3), 299-309.

²⁵ Riedel, J. E., Lynch, W., Baase, C., Hymel, P., & Peterson, K. W. (2001). The effect of disease prevention and health promotion on workplace productivity: a literature review. *American Journal of Health Promotion*, 15(3), 167-190.

²⁶ Patient Protection and Affordable Care Act, H.R. Res. H.R. 3590, 111 Cong., H.R. - House of Representatives, 4004: 1114 (2010) (enacted).

Action Steps

To address these and other issues, SOPHE will work in collaboration with other partners and stakeholders to accomplish the following external and internal actions:

External:

1. Urge Congress and the Administration at the national and state levels to address health education specialists in implementing health reform legislation, including expanding opportunities for their involvement in primary, secondary and tertiary prevention and for coverage of their services in payment mechanisms.
2. Urge the Department of Health and Human Services and its agencies (including the National Institutes of Health, Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, Food and Drug Administration, Agency for Healthcare Research and Quality, and Health Resources and Services Administration) to provide funding for research, identification, use of new technologies and dissemination of best practices for improving patient centered care, including the role of health education specialists.
3. Call for professional preparation schools and programs for health care providers, public health, allied health, health education, and health communication to strengthen professional preparation and training of health professionals about evidence-based strategies for patient-centered care, including the role of health education specialists as part of the team.
4. Urge public health and health care communities to organize and work with multi sectoral coalitions (i.e., consumers, government, businesses, and non-profit agencies) to help enroll uninsured consumers into health care plans by reducing individual and structural barriers to health literacy, promoting the dissemination of accurate health information, and involving and advocating for vulnerable populations and communities in their right to informed health decision-making.

Internal:

1. Convene an expert panel to examine the latest research and best practices in patient-centered health care, ACA implementation, and the roles of health education specialists and other professionals in promoting patients and families as active participants in decision making and treatment. Publish the findings in one of SOPHE's journals.
2. Provide continuing education for national and chapter members on ACA implementation and patient and consumer engagement as part of its national and chapter meetings and through distance education opportunities.
3. Develop and disseminate materials nationally and through its chapters to educate payers and health providers on the roles and benefits of

- including health education specialists as part of their calculations of bundled payments for the health care team.
4. Work with allied health education organizations in the next health education job analysis to identify any additional knowledge and skills should be part of the core competencies of all health education specialists in the new and evolving era of health reform.
 5. Advocate for the inclusion of health education specialists when identifying personnel for funding opportunities; job announcements; or pertinent federal/state/local legislation or regulations. SOPHE must also advocate for the use of health education specialists as opposed to lower cost and more narrowly trained classifications of employees.
 6. Expand advocacy efforts, especially on the local and regional levels, to build relationships with and educate payers and health providers to assure the calculations of the bundled payments include the health educator as part of the team.

Conclusion

As states move forward with finalizing decisions on health reform implementation, it is important to advocate for the important role that health education specialists can play in these efforts. In order to form a sustainable health care system and improve health outcomes, health education specialists should be integrated into the collaborative process of treating the “whole person”. This issue brief serves as a platform for awareness and discussion on how health education specialists can best leverage the timely opportunities that are available. SOPHE, including its leadership, chapters, and members, as well as its organizational partners and allies must address the challenges and opportunities with strategic resources and creative resolve. Working collaboratively, we can pave the way for a stronger health care system and healthier nation through inclusion of health education services for cost-effective prevention, wellness, and disease management.

Glossary of Key Terms²⁷

Accountable Care Organization: A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Affordable Care Act: The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Certified Health Education Specialist (CHES): The CHES (pronounced chez) designation signifies that an individual has met eligibility requirements for, and has successfully passed a competency-based examination demonstrating skill and knowledge of the Seven Areas of Responsibility of Health Education Specialists, upon which the credential is based.²⁸

Fee for Service: A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Health Education Specialist: An individual who has met, at a minimum, baccalaureate-level required health education academic preparation qualifications, who serves in a variety of settings, and is able to use appropriate educational strategies and methods to facilitate the development of policies, procedures, interventions, and systems conducive to the health of individuals, groups, and communities.²⁹

Health Maintenance Organization: A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Master Health Education Specialist (MCHES): The MCHES (pronounced m-chez) designation signifies that an individual has met academic eligibility with courses in health education and has met experience requirements in the health education field, passed a comprehensive written examination and has an ongoing commitment to advanced-level continuing education and professional development.³⁰

Patient-Centered Medical Home: An approach to the delivery of primary care that is patient centered, comprehensive, coordinated, accessible and committed to quality and safety.³¹

Payment Bundling (Bundled Payments): A payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

²⁷ Unless otherwise noted, definitions are from www.healthcare.gov/glossary

²⁸ National Commission for Health Education Credentialing, Inc., Accessed on March 23, 2013 at <http://www.nchec.org/aboutnchec/docs/nch-mr-tab1-133.htm>

²⁹ American Association for Health Education. Report of the 2011 Joint Committee on Health Education and Promotion Terminology. Accessed on March 25, 2013 at <http://www.aahperd.org/aahe/proDevelopment/upload/Terminology-Report-2011-final.pdf>

³⁰ National Commission for Health Education Credentialing, Inc., accessed on March 23, 2013 at <http://www.nchec.org/aboutnchec/docs/nch-mr-tab1-133.htm>

³¹ Patient-Centered Primary Care Collaborative, What is a Medical Home? Accessed on March 23, 2013 at <http://www.pcpcc.net/what-we-do>

Whole Person Orientation: The provision of coordinated health care across all elements of a patient's environment including family and community-based services.³²

³² Patient-Centered Primary Care Collaborative, Joint Principles of the Patient Centered Medical Home. Accessed on March 23, 2013 at <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>



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