

HEALTH EDUCATORS AS A THINK TANK: RECOMMENDATIONS TO IMPROVE
HEALTH CARE REFORM PROPOSALS AND POTENTIAL ROLES FOR THE
PROFESSION

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A Dissertation

Submitted in Partial Fulfillment of the Requirements for the
Doctor of Philosophy Degree in Education

Department of Health Education and Recreation
in the Graduate School
Southern Illinois University Carbondale
March, 2012

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PREFACE

Growing up I was never interested in politics or policy issues, and health care was not a topic I spent any time pondering. I did, however, have a personal passion for one thing – my mother’s health. She had chronic back pain for as long as I could remember, and I had to watch her suffer through four back surgeries before I graduated from high school. The surgeries were emotionally and physically trying on her and the entire family. They were also fiscally challenging for us. Despite the fact that my parents had (what I thought was) adequate health insurance through my father’s workplace (he was a high school math teacher), my parents had to cut out family vacations, eating out at restaurants, and birthday presents to cover the medical bills. Even with the insurance paying a significant portion of my mother’s medical bills, my parents had to pay thousands of dollars for the medical expenses and for prescriptions that my mother needed. It was during this period that I began to notice just how expensive health care costs were, even to those who are working, middle class families with health insurance.

Witnessing my parents struggle to get quality health care at an affordable price was the catalyst for my interest in health care reform issues. I began talking to other adults about their experiences with the health system, and I found out that my parents were not the only people who struggled to pay for health care even though they had health insurance. If it was hard for my family to afford it, I began to wonder how those without health insurance could afford any kind of health care. Not only that, but how does anyone with or without health insurance justify the expense of going to the doctor for anything other than an emergency?

As I was studying for preliminary examinations to become a doctoral candidate in health education, I started thinking in-depth about a noteworthy article by Dorothy Nyswander (1967).

The article presents Nyswander's philosophical views on health and health education. She believed that health education should be a part of creating an open, and just, society,

One where justice is the same for every man; where dissent is taken seriously as an index of something wrong or something needed; where diversity is respected; where pressure groups cannot stifle and control the will of the majority or castigate the individual; where education brings upward mobility to all; where the best of health care is available to all; where poverty is a community disgrace not an individual's weakness; where greed for possessions and success is replaced by inner fires for excellence and honor; where desires for power over men become satisfactions with the use of power for men (Nyswander, 1967, p. 37).

After reading this article, I decided that I wanted to be a part of creating an open society where quality health care is available to all because I believe that health care should be a right, not a privilege. I hope this study contributes a small piece of the social change necessary to achieve such a goal.

CHAPTER ONE

INTRODUCTION

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

-Dr. Martin Luther King, Jr.

Background of the Problem

“Health care touches every person who has been, or ever will be, ill” (Peters, 1999, p. 243), and illness has been around since the founding of our nation. Public health in the United States was simply sanitation during the 1700 and 1800s when urbanization, unsanitary living conditions, limited access to clean water, and poor methods of waste disposal were the primary issues affecting the health of Americans. The sanitation problems of the time led to many disease outbreaks, including a yellow fever outbreak in 1793 that forced the nation’s capital to be moved from Philadelphia, Pennsylvania. Outbreaks, such as this, prompted cities and states to develop boards of health, which led to the establishment of health departments (Duffy, 1971). Eventually, the role of health department personnel expanded from sanitation and hygiene to activities such as immunizations, health screening in public schools, and family planning; the beginning of government involvement in health care activities (Turnock, 1997). By the mid-1900s, infectious disease and sanitation problems were no longer the major threats to health. Chronic diseases such as heart disease and diabetes had now taken over as the leading causes of illness and death. Currently, approximately one-half of all Americans have at least one chronic condition (Foundation for Accountability, 2001). The problem is, however, that the American health care system still operates as an entity that treats acute illness (tertiary prevention), not as a

system that promotes wellness and prevents chronic disease (primary prevention) (Hoffman, et. al., 1996). Another problem is the emphasis on individual level behavior change instead of a multi-level approach to behavior change. Health educators and health professionals are still using primarily individual level strategies to achieve healthy behaviors in people, when evidence shows that targeting multiple levels (including societal and policy strategies) increases the likelihood of behavior change (USDHHS, 2010).

As public health practices of health changed over time, so did the health care and health insurance system. Health care reform has been a controversial topic in America since the early 1900s. The first proposal for health insurance was in the 1910s when the American Association for Labor Legislation organized a national conference on “social insurance.” This attempt at national health insurance, along with other attempts in the early 1900s, was halted by the American Medical Association. Members of the organization called national insurance a Communist plot and frightened the American public (PBS, 2010). In every decade since, there has been great tension and debate about health insurance and the health care system. The Roosevelt, Truman, Johnson, Nixon, Reagan, and Clinton Administrations (Quadagno, 2005) all attempted to significantly change the health care system, illustrating the importance of health care to the American political system and the American public. Public opinion swayed as these attempts to change the health care system came into the public eye. In the 1940s and 1950s, the AMA was successful in persuading the public that national health insurance was socialized medicine, but by 1973, most Americans wanted some kind of government/ public health insurance (Peters, 1999). Furthermore, two-thirds of Americans polled said they were in favor of national health insurance by the mid-1990s (Gallup, 1996). While most of the attempts by presidential administrations to “fix” the health care system were brought down by interest groups

or others with differing vested interests, one attempt to improve the health care system has succeeded (at least for now).

In 2007, Barack Obama announced he would be running for the presidency and was proposing a new health care plan. Shortly after his presidential inauguration he said:

I suffer no illusions that this will be an easy process. Once again, it will be hard. But I also know that nearly a century after Teddy Roosevelt first called for reform, the cost of our health care has weighed down our economy and our conscience long enough. So let there be no doubt: Health care reform cannot wait, it must not wait, and it will not wait another year (Obama, 2009, para. 59).

On March 23, 2010, the *Patient Protection and Affordable Care Act (PPACA)*; Public Law 111-148) was signed into law (USDHHS, 2010 & H.R. 3962). While there has been much controversy as to whether the *PPACA* (Public Law 111-148) is in the best interest of all Americans, many health educators would probably agree that access to health care should be a right of all citizens and the *PPACA* (Public Law 111-148) is an attempt at achieving that right for Americans. Some of the basic components of the new law include:

- Providing 32 million currently uninsured Americans with access to health insurance by 2014.
- Not allowing insurance companies to deny care based on pre-existing conditions.
- Guaranteeing basic Medicare benefits for all recipients, including free preventive services, closure of the prescription drug “donut hole (gap in prescription coverage after already spending a certain amount of yearly money; USDHHS, 2010),” and attempting to sustain the program for the next ten years by reducing the deficit.
- Allowing young adults to stay on their parents’ insurance plan until the age of 26.

- Implementing an individual mandate requiring everyone to be insured by 2014 (unless exempted for a special reason) or pay a fine.
- Creating tax credits for small businesses to aid them in the purchase of health insurance for their employees.
- Implementing state-run insurance exchanges aimed at offering affordable health care that is of the same quality as Congress' health care plans (Barry, 2010).

The underlying goal of the *PPACA* (Public Law 111-148) is to provide Americans with, “comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans” (USDHHS, 2010, para. 1).

The *PPACA* (Public Law 111-148) is an attempt to improve the current ailments of the U.S. health care system, and there are many. One is that 63% of health care spending in 2006 was allocated to approximately 10% of the population. Furthermore, 21% was spent on only 1% of the population, while only 3% of health care spending was allocated to one half of the population (KFF, 2006). In addition, total health expenditures as a percentage of Gross Domestic Product (GDP) have increased from 5.2% in 1960 to 16.0% in 2007. America spends more on health care than any other industrialized nation (National Center for Health Statistics, 2011). Despite spending more, we have many people who are unable to receive health care. In 2009, the total number of uninsured Americans reached 46.3 million (CDC, 2009). The U.S. ranks 176th of the world's countries in infant mortality rate (6.06 deaths per 1,000 live births) (a ranking of 1 would be the lowest infant mortality rate), and it is 50th in life expectancy (78.37 years) (CIA, 2010). It is easy to see that a change in the health care system is needed, but is the *PPACA* (Public Law 111-148) the right change?

Need for the Study

Prior to this study, there was no research examining health educators' beliefs and behaviors regarding health care reform issues, specifically, and limited research regarding health educators' beliefs toward behaviors surrounding policy issues, in general. To date, only one quantitative study was located that analyzed health educators' behaviors related to health policy (Holtrop, Price, & Boardley, 2000). Holtrop, Price, and Boardley (2000) administered a survey to health educators to determine their level of involvement in policy activities, their perceptions about policy involvement, the relationship between self-efficacy and policy involvement, and the factors that predict involvement in policy activities. They found health educators were involved in policy activities, but many only participated in two or fewer policy activities over two years. Also, those health educators most involved in policy activities had higher self-efficacy. Finally, the study found that health educators were most involved in influencing policy makers as well as being a resource person for policy information (Holtrop, Price, & Boardley, 2000). In addition, no studies were found using qualitative research designs to study health educators' experience with and recommendations for any policy issues, including health care reform issues. Due to the lack of existing research and the importance of health care reform to American society, I thought it was essential to conduct in-depth discussions with health educators' to explore their beliefs about and recommendations for this policy issue.

Purpose of the Study

The primary purpose of this study was to explore recommendations from health educators for health care reform in relation to the different levels of the determinants of health ecological

model. Additionally, this study examined the potential new roles participants identified as important for the health education profession in achieving an effective health care system.

Research Questions

- 1) From a health education perspective, what individual, health service, societal, and policy components should be in place for a successful health care reform plan to succeed?
- 2) What roles in health care reform do participants see as potential roles for health education professionals?
- 3) How do health educators advocate or act on policy issues related to access to health care/ health care reform?

Significance to Health Education

Many people in the United States do not have access to and do not receive quality, affordable care when they need it. In addition, the already strained health care system will encounter up to 32 million new patients in 2014 as a result of the *PPACA* (Public Law 111-148). Furthermore, over half of all Americans are not adequately engaged in their health and health care, especially low income, less educated, *Medicaid* (Public Law 89-97) enrollees with poor self-reported health. These disengaged Americans are lacking the knowledge, skills, and self-efficacy to take an active role in promoting their health and accessing health care (Hibbard & Cunningham, 2008). All of these issues, and others, make the measurement and development of new strategies and models essential (USDHHS, 2011). One of the topic areas of *Healthy People 2020* is access to health services. Access to health services is important for Americans as they attempt to achieve health equity and an increased quality, healthy life. When people have access to health care, they are more likely to have better physical, social, and mental health status, prevent disease and disability, detect and treat health conditions, and have a higher quality of life and

longer life expectancy. Conversely, with no or limited access to health care, people's ability to reach their full potential is decreased, which negatively affects their quality of life (USDHHS, 2011). Health educators devote their work and research to helping the USDHHS (via *Healthy People* goals) accomplish the decade-long health goals, and access to health care should not get overlooked. Currently, there are many CHES continuing education credit activities devoted to health care reform topics, so health educators can learn about health care reform issues and better serve as resource persons on the topic. Because of the responsibility and the opportunities available to health educators, the profession is in a unique position to influence the health care system to promote prevention and overall health (NCHEC, 2008).

Not only do health educators strive to plan and implement programs that aid America in reaching its health goals for each decade, but they also have a responsibility to communicate and advocate for health and health education, including influencing health policy to promote health (NCHEC, 2008). The *PPACA* (Public Law 111-148) is an important health policy for health educators to influence because lack of access to health services/care leads to unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been prevented. With an ethical responsibility to the public, health educators must strive to “promote, maintain, and improve individual, family, and community health” (NCHEC, 2000); and the *PPACA* (Public Law 111-148) is a policy that will greatly affect the health of many individuals, families and communities. Health educators also have a responsibility to conduct research to influence the health status of Americans and to serve as resource persons on health related topics; therefore, it is important for the profession to be involved in research regarding health care reform and its influence on the health of Americans (NCHEC, 2008).

The future of the *PPACA* (Public Law 111-148) is uncertain, but what is certain is that access to health care and the health care system is likely to be controversial for many years to come. With a vested interest in the health of Americans and professional training in planning, implementing, and evaluating health programs, health educators are a group of professionals that have valuable advice to give regarding the health care system changes needed to improve the health of individuals, families, and communities. With the results of this study, the health education profession can compile their suggestions into a position statement/ policy analysis brief in order to influence policy makers and politicians in Washington D.C. (and in their local communities). They can aid communities in planning effective programs that address multiple determinants of health to increase access to health care services. They can even fulfill new professional roles in the strained health care system by educating and developing resource materials for the 32 million newly insured Americans (USDHHS, 2010).

There are funds allocated for prevention and public health through the *PPACA* (Public Law 111-148) for which health educators may be eligible to apply. The prevention and public health fund will support programs for prevention wellness and public health activities, including prevention research and health screenings. Funding levels are as follows: \$750 million for fiscal year 2011, \$1 billion for 2012, \$1.25 billion for 2013, \$1.5 billion for 2014, and \$2 billion for 2015 and each year after (H.R. 3962).

Research Design

This qualitative study was based on an interpretivist research paradigm in which the ultimate aim was to understand and interpret. With interpretivist research, knowledge is subjective, contextualized, value-laden, and specific (Lather and Pierre, 2006). The aim of this particular study was to gain contextualized, value-laden, specific knowledge from health

educators to understand and interpret their perceptions about what needs to be in place on multiple levels for health care reform to be successful, including roles for the health education profession. The research methodology utilized in this study was theory-driven, using the *Healthy People 2020* determinants of health ecological model (USDHHS, 2011). Determinants of health include biology and genetics, individual behavior, health services, social factors, and policymaking. According to the USDHHS (*Healthy People 2020*; 2011) interrelationships among these determinants influence the health of individuals and communities; so targeting multiple determinants of health increases effectiveness – including health care reform.

Data Collection

The sampling frame for this study was Certified Health Education Specialists (CHES) and Masters Certified Health Education Specialists (MCHES) who are committed to health care reform. Maximum variation purposeful sampling was used to identify those health educators who represent a wide range of characteristics of interest (Merriam, 2009). The characteristics of interest were workplace setting (community, medical, post-secondary, school, worksite, and organization/foundation), years of experience in the profession, and gender. Basically, the sample consisted of health educators in all six major workplace settings, where each workplace setting group was comprised of male and female health educators with various years of experience in the field of health education.

After human subjects approval was granted (see Appendix A), a list of all CHES and MCHES health educators (see Appendices B and C) was purchased from the National Commission for Health Education Credentialing, Inc., and health educators were identified based on workplace setting, years of experience in the profession, and gender. An email was sent to potential participants to recruit them for the study (see Appendix D). The email asked

participants if they felt committed to health care reform, and those health educators who responded by indicating they did feel committed were selected to participate in the study. As the researcher, I believed those health educators who were committed to health care reform would be better able to provide in-depth, thoughtful recommendations for health care reform and the potential roles for health educators within the health care system. A commitment to health care reform was chosen as selection criteria over knowledge about health care reform because health educators may be able to provide recommendations for the health care system without having a great deal of knowledge about health care reform and without having studied health care reform issues. As an incentive for participating in this study, participants were entered into a drawing to receive a copy of the entire *PPACA* (Public Law 111-148), as well as four recently published books on the topic of health care reform.

Once participants were identified, multiple online chat room focus groups were organized and conducted in real-time. Focus groups lasted approximately 50 minutes and were organized according to workplace setting to keep the number of participants in each group small enough to encourage participation from all and to enable in-depth discussion of all research questions. The chat room focus groups was piloted multiple times before the study began with 4-10 health education doctoral students from Southern Illinois University Carbondale. Piloting the focus groups allowed me to determine the optimum number of participants to include in each focus group and to work out any problems that occurred with the chat room software and the process (assigning code names to ensure anonymity, successfully moderating the focus groups, allowing sufficient time for each question, etc.). Focus group questions were based on the research questions and elicited recommendations about the potential roles for health educators in health care reform and the individual, health service, societal, and policy components that should be in

place for an effective health care reform plan to succeed (from the *Healthy People 2020* determinants of health ecological model). The text from the online focus groups was saved as a Word file to enable thorough data analysis.

Data Analysis

Data was sorted into predetermined categories according to the research questions. Once data was categorized, each category's responses was sorted to identify recommendation areas and specific recommendations; recommendation areas were organized topically; and rich, thick descriptions from the chat focus group and interview transcripts were utilized to give meaning to each recommendation. Overarching themes were also explored and determined as the themes that linked all levels of the *Healthy People 2020* determinants of health ecological model and the majority of recommendations. In addition, data analysis was ongoing, beginning after the first focus group and continuing until all focus groups and interviews were completed and data was saturated. Member checking was used to solicit feedback about the emerging recommendation areas and overarching themes from focus group participants as well as increasing credibility of the study (Merriam, 2009). I conducted all data analysis, and no computer software was used to identify recommendation areas or overarching themes. To describe thoughts and feelings after each focus group and interview, I kept a reflective journal. Describing thoughts and feelings after each focus group and interview allowed for identification of any biases and subjectivities, along with contributing to the reflexivity of the results (audience should be able to get a representation of my viewpoint throughout so they can make their own assumptions about the trustworthiness of the results). The focus group and interview transcripts, reflective journal entries, and peer review (scanning of the data by a colleague to determine if the

recommendations and themes are accurate [Merriam, 2009, p. 220]) contributed to triangulation (use of multiple sources of data to confirm findings [Denzin, 1978]).

Assumptions

An assumption is a fact concerning the study that is established but cannot necessarily be proven true (Neutens & Rubinson, 2010). This study was based on the following assumptions:

1. Participants were committed to health care reform.
2. Participants were honest during the focus group sessions.
3. Participants shared their opinions during focus group sessions.
4. Participants were engaged as they participate in the focus groups and answered questions regarding health care reform.
5. Study results are not intended to be generalizable to the entire population.

Delimitations

Delimitations address how the study will be narrowed in scope, or how it is bounded (Pajares, 2007) . The following delimitations should be considered when interpreting results of this study:

1. The study sample included only health educators who are CHES or MCHES certified, therefore some perspectives from health educators who were not CHES or MCHES certified might not have been expressed in the results of the study.
2. The study participants were representative of the following workplace settings: community, medical, post-secondary, school, worksite, and organization/foundation.
3. Chat room focus groups conducted in real-time was the means of data collection.
4. Focus groups were arranged according to workplace settings.

Limitations

Limitations identify potential weaknesses of a study (Pajares, 2007). The following limitations should be considered when interpreting results of this study:

1. My personal subjectivities (beliefs about, biases toward, and experiences with health care reform) may have influenced data analysis and results.
2. Computer access or computer literacy may have influenced the final study sample as some health education specialists may have declined to participate in the study because they were not comfortable using technologies, such as online chat room focus group websites.
3. Electronic failures during data collection may have affected the amount of data gathered as well as the results of the study.
4. Some participants were more articulate and detailed than others.

Definition of Terms

Access refers to “the ability of persons needing health services to obtain appropriate care in a timely manner. Can you get medical care when you need it? If yes, you have access to medical care. Access is not the same as health insurance coverage, although insurance coverage is a strong predictor of access for primary care services” (Shi & Singh, 2008, p. 595).

Advocacy is “a process which includes community organizing, coalition building, education, and lobbying public officials on behalf of the public’s health” (Thomas, 1990, p. 18).

Certified Health Education Specialists (CHES) are “those who have met the standards of competence established by the National Commission for Health Education Credentialing, Inc. (NCHEC) and have successfully passed the CHES examination (National Commission for Health Education Credentialing, Inc., 2008, Health education credentialing section, para. 5).”

Determinants of Health are “the biological, environmental, behavioral, organizational, political, and social factors that contribute to the health status of individuals, groups, and communities (Joint Committee on Health Education and Promotion Terminology, 2001, p. 99).”

Disparities are “differences in the quality of healthcare or the health outcomes of different groups of people (e.g., racial/ethnic, socioeconomic, gender) that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions (Shi & Singh, 2008, p. 601).”

Health Advocacy is “the process by which the actions of individuals or groups attempt to bring about social and/or organizational change on behalf of a particular health goal, program, interest, or population (Joint Committee on Health Education and Promotion Terminology, 2001, p. 99).”

Health Education is “any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions (Joint Committee on Health Education and Promotion Terminology, 2001, p. 99).”

A *Health Educator* is “a professionally prepared individual who serves in a variety of roles and is specifically trained 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 (Joint Committee on Health Education and Promotion Terminology, 2001, p. 100).”

A *Health Outcome* is “a measureable change in or reinforcement of factors related to health status or quality of life attributable to a series of events, planned or unplanned (Joint Committee on Health Education and Promotion Terminology, 2001, p. 100).”

Health Policy is any public policy that influences the health of the population (Batra, 1992).

An *Interest Group* is “an organized sector of society, such as a business association, citizen group, labor union, or professional association, whose main purpose is to protect its members’ interests through active participation in the policymaking process (Shi & Singh, 2008, p. 605).”

A *Master Certified Health Education Specialist (MCHES)* is “an individual that has met academic eligibility in health education and is practicing at the advanced-level in the field, passed a written examination administered by the National Commission for Health Education Credentialing, Inc., and has an ongoing commitment to continuing education (NCHEC, 2008, MCHES overview section, para. 1).”

Passion is having a very strong feeling for something or someone (Oxford University Press, 2011).

Prevention refers to “actions and interventions designed to identify risks and reduce susceptibility or exposure to health threats prior to disease onset (primary prevention), detect and treat disease in early stages to prevent progress or recurrence (secondary prevention), and alleviate the effects of disease and injury (tertiary prevention) (Joint Committee on Health Education and Promotion Terminology, 2001, p. 101).”

Public Health has a mission of “fulfilling society’s interest in assuring conditions in which people can be healthy. Public health deals with broad societal concerns about ensuring conditions that promote optimum health for society as a whole (IOM, 1988, p. 7).”

Public Policy is “the sum of government activities, whether pursued directly or through agents, as those activities have an influence on the lives of citizens (Peters, 1999, p. 4).”

Quality refers to “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (IOM, 1990, IOM definition of quality section, para. 1).”

A *Think Tank* is “an institute, corporation, or group organized for interdisciplinary research such as technological or social problems (Merriam-Webster Dictionary, 2011, Think tank definition section, para. 1).”

The *Uninsured* are “those without private or public health insurance coverage (Shi & Singh, 2008, p. 8).”

Universal access occurs “when health care is available to all citizens. Countries with national health care programs provide universal access (Shi & Singh, 2008, p. 11).”

Summary

The *Patient Protection and Affordable Care Act* (Public Law 111-148) espouses a policy of seeking to improve the current ailments of the U.S. health care system and to ensure that health and health care are rights of all citizens. Because health educators have a responsibility to communicate and advocate for health and health education, including influencing health policy to promote health, the profession is in a unique position to make recommendations for this policy and for health care reform in general. However, qualitative data describing health care reform recommendations from a health educator’s perspective did not exist prior to this research.

This interpretivist, qualitative study explored recommendations from health educators about the potential roles for health educators in health care reform and the individual, health service, societal, and policy components that should be in place for an ideal health care reform plan to succeed. This chapter included background about health care reform and the *PPACA*

(Public Law 111-148), study purpose, research design and questions, data collection and analysis, assumptions, limitations, delimitations, and definitions of relevant terms for this study.

CHAPTER TWO

LITERATURE REVIEW

Purpose of the Study

The primary purpose of this study was to explore recommendations from health educators for health care reform in relation to the different levels of the determinants of health ecological model. Additionally, this study examined the potential new roles participants identified as important for the health education profession in achieving an effective health care system.

A History of Health Care Reform in the United States

Health insurance and health care reform have been policy issues in the United States for nearly a century. In 1912, Theodore Roosevelt campaigned for a health system to provide health insurance for American industry (Kaiser Family Foundation, 2009). The American Association for Labor Legislation held a national conference about “social insurance” during this time as well (PBS, 2010). Almost a century later, health care reform continues to be a major issue for the U.S. government and the American public (KFF, 2009).

During the century of debates and political activity surrounding health care reform, nearly every presidential administration proposed a health care reform bill. Historians believe there are many lessons to be learned from exploring the bills, their success or failure, and the political and American climate during the various periods (KFF, 2009; Stevens, Rosenberg, & Burns, 2006). According to researchers at the Kaiser Family Foundation (2009), the first major period of health care reform policy occurred from 1934-1939. Because of the Great Depression, there were many disparities in access to health services. Medical costs rose at this time, and illness was known to be a major cause of poverty. Because of these social problems, groups (including workers, unemployed citizens, veterans, and the elderly) organized to request

government funded health protection. President Roosevelt drafted a health insurance proposal that consisted of state-run systems with federal subsidies and minimum health insurance standards. The proposal also called for expansion of hospitals, public health, maternal services, and child services where each state could decide whether or not to participate in the program (KFF, 2009), as was the case for many government bills on social issues during this time period (Peters, 1999). Because unemployment seemed to be a larger issue during this time and those in the AMA exerted force to stop implementation of national health insurance, President Roosevelt's proposal never made it into the final draft of the *Social Security Act* (Public Law 89-97) and health care reform did not succeed during this period (KFF, 2009).

The next major period of health care reform in the U.S. occurred during the Truman administration from 1945-1950 (KFF, 2009). This reform era followed World War II when large employers such as General Motors and AT&T began using health insurance plans to recruit new employees. Veterans had money to spend, helping capitalism prosper, and they were starting families, thus making health insurance a valuable commodity. President Truman's health reform proposal was part of his "Fair Deal" policy. The "Fair Deal" consisted of a national, single insurance system to insure all citizens. It also incorporated subsidies to pay for the poor, and it emphasized construction and expansion of hospitals. Again, this health care policy was defeated and never became law because the AMA and other opponents used scare-tactics that made the American public believe national health insurance was a method of government control and socialism during a time period when communism was expanding in Germany and China. The *Hill-Burton Act* (Public Law 79-725) was passed separately, however, to provide funding to construct and expand hospitals in the United States (KFF, 2009).

By 1950, national health care expenditures exceeded 4.5% of the Gross Domestic Product (PBS, 2010). By the 1960s, the health care industry had exploded and over 700 insurance companies were selling health insurance. The first major success in health reform history occurred between 1960-1965. This era marked a time when the retired or sick elderly found it very difficult to purchase affordable health insurance. As a response to this “problem,” the *Kerr-Mills Act* (Public Law 86-778) was passed, allowing states to receive federal grants to pay for the elders’ health insurance. This act, however, was not successful because just over half of the states participated. The major health care reform policy of this time emerged from multiple proposals. As proposals were debated and narrowed, the final reform proposal was eventually composed of *Medicare Part A*, *Medicare Part B*, and *Medicaid* (Public Law 89-97; KFF, 2009; PBS, 2010). *Medicare Part A* (Public Law 89-97) emerged to fund hospital stays, nursing home stays, and home health care for the elderly age 65 and older and those with end-stage renal disease (ESRD). *Medicare Part B* (Public Law 89-97) paid for shorter-term care, such as doctor’s visits, for the elderly and those with ESRD (USDHHS, N.D.). *Medicare* (Public Law 89-97), on the other hand, provides coverage to 39 million senior citizens aged 65 and older (Almanac of Policy Issues, 2010). *Medicaid* (Public Law 89-97) was developed to assist states in covering low-income, vulnerable citizens that could not afford health insurance, including low income women, children, elderly, and those with disabilities (Almanac of Policy Issues, 2010). President Kennedy, as well as President Johnson, supported *Medicare* (Public Law 89-97). President Johnson moved very quickly after being elected into office, and even stated, “Every day while I’m in office, I’m gonna lose votes... We need... [*Medicare*] fast” (Blumenthal & Monroe, 2009, p. 172). *Medicare* and *Medicaid* were passed as amendments to the *Social Security Act* (Public Law 89-97) in 1965, and the successful passage of these large, government-

run health insurance reforms can be largely attributed to President Johnson's leadership skills and urgency to pass the reform, a Democratic majority in Congress, and public support from American citizens (KFF, 2009).

The next period for health care reform efforts occurred during President Nixon's administration between 1970-1974 (KFF, 2009). During this period of time, health care costs rose a great deal due to *Medicare* (Public Law 89-97) expenditures, economic inflation, rising hospital costs, and an increased use of medical technologies (PBS, 2010). The spark for health reform proposals in the 70's can be traced to Senator Edward (Ted) Kennedy, who held health care hearings all over the United States and wrote *The Health Care Crisis in America* (Kennedy, 1972). Kennedy's reform plan was called the "Health Security Act." It called for universal coverage through a single-payer system that would be paid for by payroll taxes of citizens. President Nixon also had a health reform plan of his own. His plan was called the "*Comprehensive Health Insurance Plan*" (CHIP; Public Law 111-3). This plan also called for universal coverage, but it differed in having voluntary employer participation, and it replaced *Medicaid* (Public Law 89-97) with a separate program. Nixon's plan was to be funded by requiring employers to pay 65% of health insurance premium costs. While these proposals were the two primary health insurance proposals of the era, they were not the only ones. It was the fact that there were many competing health reform proposals, along with the Watergate scandal, that ultimately led to the defeat of health care reform from 1970-1974 (KFF, 2009).

The next period, from 1976-1979, did not have much more success than the previous. President Carter supported national health insurance, but the era was marked by little economic growth, high rates of inflation, and high unemployment; he wanted to improve the economy before drafting and supporting a national health care reform policy. Senator Kennedy drafted

another health reform proposal during this period. This proposal consisted of competition between private insurance companies for health care consumers where the consumers were given a card to use for health services. Citizens would pay for the card based on income, but employers were the primary financiers of the program. Shortly after Kennedy released his proposal, President Carter released a different proposal calling for expansion of health care insurance coverage for the poor and elderly, a minimum package of health insurance benefits from businesses, and creation of a new public company to offer health insurance coverage to all other citizens. It was a combination of the conservative ideologies of the time, the recession, high rates of inflation, and seemingly uncontrollable health care costs that kept these health care reform proposals from being accepted (KFF, 2009).

During the 1980s federal debt reached record levels, and by the 1990s health care costs had risen at a rate double the rate of inflation (PBS, 2010). In 1990 health care costs accounted for 12% of the U.S. Gross Domestic Product (GDP; KFF, 2009). This period for health care reform proposals occurred between 1992-1994 as a response to the health care “crisis” in America and public opinion polls that showed Americans were increasingly worried about how they were going to pay for their health care. President Clinton’s health care reform proposal was called the “Health Security Act,” (not to be confused with Senator Ted Kennedy’s “Health Security Act” proposed during the 1970’s) and it was based on universal coverage, employer mandates to provide insurance coverage, individual mandates to purchase insurance coverage, and insurance company competition. Clinton’s plan was accompanied by many other plans, and it was the competition among plans that played a partial role in the proposal’s failure. Other factors contributing to the failure of the “Health Security Act” were the complexity of the Act, the size of the Act (it was over 1,400 pages long), and well organized opposition from groups

such as the Health Insurance Association of America (HIAA) and the National Federation of Independent Businesses (NFIB; a leading opponent of today's *Patient Protection and Affordable Care Act* [KFF, 2009; Health Care Lawsuits, 2010]). There was one health policy success during the Clinton administration, however. It was the *Children's Health Insurance Program* (Public Law 111-3) that built on *Medicaid* (Public Law 89-97) to offer coverage to increasing numbers of low-income children (KFF, 2009).

Fuchs (2009) suggests four reasons why all previous attempts to reform health care in America failed: 1) many people prefer the status quo over an uncertain, unfamiliar change, 2) the "Law of Reform" which says that the concentrated minority of opponents have more power over reform than the diffuse majority, 3) special interest groups and complex political processes make it difficult to actually pass health care reform proposals, and 4) health care reformers throughout history have not been able to support a single plan. Morone (2010), on the other hand, suggests a number of lessons learned for President Obama's administration based on these past health care reform attempts. Some of the lessons learned include acting with speed like the Johnson administration, developing a health care plan based on principles, not complex details (learned from the complex Clinton health care reform plan that did not make it to Congress), and learning how to move forward once defeated, much like President Truman who is now considered an inspiration to many health care reformers (Morone, 2010).

Characteristics of the U. S. Health Care System

For over a century, the United States health care delivery system has been organized and run according to ten basic characteristics (Shi & Singh, 2008):

- 1) Unlike many other countries, the United States has a health care system that is not governed by a central agency. Here most of our hospitals, physician clinics, etc., are privately run

businesses. No central agency controls finances or expenditures, making employers the largest financiers of health care services (Shi & Singh, 2008).

2) Other countries have universal coverage and access to health care services, meaning that health care is available to all of the country's citizens. In contrast, access to health care in the United States is only available to some groups of people. In the United States, citizens can be covered through health insurance provided by their employer. If they aren't employed or their employer doesn't offer health insurance they may be covered by a government health care program (such as Medicaid), but only if they qualify. Others may choose to purchase health insurance out of their own funds, and still others may just pay for services out-of-pocket without having insurance. If a person is uninsured (and there are over 40 million uninsured) in the United States (CDC, 2009) and they can't afford to pay for health care services out-of-pocket, they will most likely avoid treatment until a trip to the Emergency Department is necessary. If an uninsured person who can't afford to pay for treatment comes to the Emergency Department for care, the hospital will most likely not receive any direct payment for treating the patient and the American public will end up paying for the bill (Shi & Singh, 2008).

3) U.S. citizens always pride themselves as having a health care system operated under free market conditions, but in reality the system can be characterized as an imperfect market at best. Under free market conditions buyers and sellers act independently of one another, but in all actuality, patients (buyers) cannot choose to receive their health care services from any provider/doctor (seller). The rules of supply and demand also apply under a free market system in which price and quantity of product demanded are inversely related. In our health care system, prices are set by payers, or insurance companies, instead of the result of patients' demand for a treatment or procedure. In other words, prices are not likely to go down if patients stop

requesting/ demanding a treatment. Even at the most basic level patients in the United States cannot base their decision to purchase a treatment or procedure solely on price or quality of the product. Here the decision to purchase a treatment or procedure is largely determined by need for the product (e.g. a heart transplant) and the physician's influence. Many people will not shop around to find the cheapest treatment, test, medication, or doctor; and they are not likely to question the advice of their trusted medical provider (Shi & Singh, 2008).

4) Another characteristic of the United States health care delivery system is the presence of third-party insurers and payers. We often assume that health care services are paid for by the patient (the first party) to the medical provider (the second party), but in reality the insurance companies (third parties) are almost always a part of the transaction. This means that providers and patients have limited say in the payment process as they have to comply with the policies and procedures set by their respective insurance company (Shi & Singh, 2008).

5) Countries that have universal health care systems have a single-payer (usually the government). The United States, however, has a multiple-payer system where each employer has the opportunity to decide which health insurance plan it offers for its employees. Individuals who purchase health insurance packages out-of-pocket also have this right. The presence of multiple payers promotes a system that is cumbersome because it is difficult for physicians and clinics to keep track of all the different health plans, payments can be denied by the payer if requirements for reimbursement are not exactly followed, collection efforts often take a great deal of time, and in-depth documentation is required by government programs/ payers like Medicare (Shi & Singh, 2008).

6) The United States health care delivery system also has a much larger number of stakeholders that have different vested interests when it comes to health care. For example, many physicians

want to maximize their income and have total control over their medical practice. Insurance companies are interested in obtaining and maintaining a large share of the insurance market. Individuals want to receive quality care at minimal cost. Other stakeholders include large employers, the government, and lobbyists. The problem with multiple stakeholders is that they often have competing interests (Shi & Singh, 2008).

7) Where countries that have universal health care systems run by the government are immune from lawsuits, those that practice medicine in the United States take the risk of incurring a malpractice lawsuit because people are motivated by the idea that they can receive monetary payment for alleged harm brought on by their practitioner. While it is good to have a system aimed at protecting the health and rights of Americans, the right to file lawsuits also promotes defensive medicine that wastes money, time, and resources (Shi & Singh, 2008).

8) The U.S. health care delivery system also has been characterized by research and the constant influx of new medical technologies. The United States is a society that demands the newest and “best” treatments, procedures, equipment, etc.; and, in return, has to pay increasing amounts for this ever-changing technology. Medical technologies in the United States cause hospitals and clinics to compete based on who has the most up-to-date equipment, and forces large investments to be made that have to be recouped by higher prices and premiums for patients (Shi & Singh, 2008).

9) The U.S. health care system also offers a continuum of health care services; not simply curative, restorative, and preventive services that define the systems in other countries. The system offers preventive care, primary care, specialized care, chronic care, long-term care, sub-acute care, acute care, rehabilitative care, and even end-of-life care (Shi & Singh, 2008).

10) A final characteristic of the U.S. health care system is an emphasis on quality standards. With the onset of technologies, continuums of services, and a variety of providers, Americans are demanding improved health outcomes and quality of services (Shi & Singh, 2008).

Fuchs (2009), a prominent researcher in health care reform issues, discusses eight characteristics of the United States health care system compared to other industrialized countries. First, he speaks of the high administration costs of the U. S., as illustrated by the fact that we have hundreds of thousands of doctors, 50 states with different health care regulations, and hundreds of independent insurance companies all working differently. Secondly, the U.S. has many more specialist physicians than primary care physicians (Fuchs, 2009); less than one-third are primary care physicians (US Bureau of Census, 2009). Third, the U.S. has expensive equipment such as magnetic resonance imaging scanners that are not utilized very often. This low rate of utilization compared to high prevalence raises prices for the use of the equipment. Fourth, the U.S. does not have a fixed budget for health care, meaning that spending on health care could be unending. Fifth, medical malpractice is prevalent in the U.S., increasing the cost of malpractice insurance and the existence of defensive medicine. Sixth, there is a lack of social support for the poor and uneducated citizens of America, which causes Emergency Department usage to rise resulting in higher health care costs for everyone else. Seventh, the U.S. allows drug companies to charge higher prices to American citizens and lower prices to citizens of other countries. Finally, doctors typically have higher incomes than Americans in other professions (Fuchs, 2009). After review of these characteristics, it is understandable that the health care system is expensive and there are large disparities in health care access.

Current Need for Health Care Reform

The characteristics described above illustrate the need for health care reform in the United States. Some of the other causes of the “problem” are the strong philosophical differences between parties about the meaning of health and whether it is a right or a privilege, and whether the government should interfere. While Democrats usually favor and promote spending on social issues such as health and health care, Republicans tend to think the government should not interfere with health as they become more involved in interest group politics and have a primary concern to avoid spending money on social issues (Peters, 2008). Another “problem” is the simple fact that health care reform policies tend to be large and very complex (much like the *PPACA*; Public Law 111-148), and, even if they get passed, the chances of timely, successful implementation are slim. There has to be money available to make the changes, and there have to be organizations and people allocated to follow through with the changes and implementation. Often times, those resources get overlooked or purposefully ignored (Peters, 2008).

To understand the current need for health care reform, one can compare the U.S. health care system to those in other countries and also simply analyze the system within the nation. According to the Commonwealth Fund’s 2010 update survey (Davis, Schoen, & Stremikis, 2010), “U.S. spends more on health care than any other country and has the highest rate of specialist physicians per capita. Survey findings indicate that from the patient’s perspective, the quality of American health care is severely lacking. The nation’s substantial investment in health care is not yielding returns in terms of public satisfaction (p. 16).” The United States ranks last overall of seven industrialized countries (Australia, Canada, Germany, Netherlands, New Zealand, United Kingdom, and United States) in measures of quality care, access, efficiency, equity, health expenditures, and long, healthy, productive lives of citizens. The countries in this

study were selected because they are all industrialized, and the data are based on national mortality data as well as perceptions and experiences of patients and physicians (Davis, Schoen, & Stremikis, 2010). See Table 1 for information on the seven countries' rankings on health indicators.

Table 1

Country Rankings for Health System Indicators Based on National Mortality Data, and Perceptions and Experiences of Patients and Physicians

	Australia	Canada	Germany	Netherlands	New Zealand	U.K.	U.S.
Overall Ranking	3	6	4	1	5	2	7
Quality of Care	4	7	5	2	1	3	6
Access	6.5	5	3	1	4	2	6.5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy Lives	1	2	3	4	5	6	7
Health Costs/ Capita	\$3,357	\$3,895	\$3,588	\$3,837	\$2,454	\$2,992	\$7,290

Note. Table referencing data from Davis, Schoen, & Stremikis (2010)

Another study compared 11 industrialized countries (Australia, Canada, Denmark, France, Germany, Netherlands, New Zealand, Sweden, Switzerland, United Kingdom, and the United States) based on spending, hospitals, long-term care, physicians, pharmaceuticals, prevention, and mortality and their various health indicators in 2006 (Anderson & Markovich, 2008). Results indicate that out-of-pocket health care spending per capita for the U.S. was

\$857.00 per person, second only to Switzerland. Americans also spent more on total health care spending for health insurance and administration per capita spending \$486.00 per person. The average hospital length of stay in days for acute care is 5.6 days. This figure can be compared to 3.5 days for the shortest length of stay in Denmark and 8.5 days as the longest length of stay in Germany. The U.S. ranks first in the number of coronary bypass procedures with 145 procedures per 100,000 people. Furthermore, America ranks first in potential years of life lost due to diabetes with 99 years lost per 100,000 people. Lastly, both male and female life expectancy at birth in the U.S. is lowest among all 11 countries with male life expectancy of 75.2 and female life expectancy of 80.4 (Anderson & Markovich, 2008). While it is not necessary for the U.S. to rank first in every category and there is room for improvement in every country, U.S. citizens are not getting good health care for their dollar (Monegain, 2010).

When looking only at the United States health care system, a possible indicator for the need for health care reform is the number of uninsured Americans. In 2009, the number of uninsured was estimated by the U.S. Census Bureau to be 50.7 million people, or 16.7% of the population (DeNavas-Walt, Proctor, & Smith, 2010). See Table 2 for U.S. health insurance figures in 2008 and 2009, and Table 3 for figures of uninsured Americans from 1999-2009. O'Neill and O'Neill (2007) further identify the uninsured by being "involuntarily" uninsured (not being able to afford health insurance) or "voluntarily" uninsured (affording health insurance). Their data were based on the 2006 rate, or 47 million, of uninsured. They found that 43% of the 47 million uninsured Americans aged 18-64 had incomes at least 2.5 times the poverty rate suggesting that this group of uninsured should be able to afford health insurance and are therefore classified as "voluntarily" uninsured (O'Neill & O'Neill, 2007). In addition, they

estimated that the “involuntarily” uninsured Americans are likely to be young, high school dropouts, immigrants, single people with no children, or unemployed (O’Neill & O’Neill, 2007).

Table 2

U.S. Health Insurance Figures: 2008 and 2009 (in millions)

	Uninsured	Private	Employer	Government	Medicaid	Medicare
2008	46.3	201.0	176.3	87.4	42.6	43.4
	(15.4%)	(66.7%)	(58.5%)	(29.0%)	(14.1%)	(14.3%)
2009	50.7	194.5	169.7	93.2	47.8	43.4
	(16.7%)	(63.9%)	(55.8%)	(30.6%)	(15.7%)	(14.3%)

Note. Table referencing data from DeNavas-Walt, Proctor, & Smith (2010)

Table 3

Number of Uninsured Americans from 1999-2009 (in percentages %)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
< 18	11.9	12.6	11.2	10.9	9.8	9.2	9.3	9.5	9.0	9.0	8.2
18-44	21.0	22.4	22.2	23.0	23.5	23.5	23.5	24.6	23.9	24.4	25.9
45-64	12.2	12.6	12.2	13.1	12.5	12.8	12.9	13.2	13.5	13.6	14.6

Note. Table referencing data from National Center for Health Statistics (2011)

In addition to looking at the number of uninsured Americans to illustrate the need for health care reform, an analysis of health care spending also will help to make the point. In 2007, the Congressional Budget Office (CBO) estimated that health care expenditures had grown 2.8% faster each year than the rest of the economy in the past thirty years, and they further estimated that in the next 30 years health care spending will account for 30% of the GDP (CBO, 2007).

Also, the Centers for Medicare and Medicaid Services (CMS; 2009) estimated total health care

spending of over \$2.5 trillion, or \$8,160 per person, in 2009. They project total health care spending to reach \$4.3 trillion, or \$13,100 per person, by 2018 (CMS, 2009).

The overall estimates for health care spending may be alarming to some, but the concentration of health care spending in the U.S. may be even more alarming. Sixty-three percent of health care spending in 2006 was allocated to approximately 10% of the population. Furthermore, 21% was spent on only 1% of the population while only 3% of health care spending was allocated to one half of the population (KFF, 2006).

The high cost of health care in the U.S. is a cause of health care disparities. According to Agency for Healthcare Research and Quality (2004), some of the disparities in health care that exist in America are:

- Minorities are more likely than whites to be diagnosed with late-stage breast cancer and colorectal cancer.
- Those of lower socioeconomic status are less likely to receive recommended diabetic treatments and more likely to be hospitalized because of complication of diabetes.
- Higher rates of avoidable hospital conditions are prevalent in black and poor Americans.
- Reports of unmet health needs are most likely to come from Hispanics and those of low socioeconomic status.
- Racial and ethnic minorities are less likely than whites to report health insurance (AHRQ, 2004).

While limited research has been conducted to determine why these disparities exist, authors of the AHRQ report suggest that reducing health care disparities is indeed possible (AHRQ, 2004). By learning what disparities exist in which populations, public health professionals (including

health education specialists) can target their programs and services to reduce the disparities.

They also can study the “best” health performing groups to determine which skills and services are most helpful and apply them to the groups most in need.

The consequences of having high health care costs can have a negative influence on the health of the American population, as illustrated by the results of the Kaiser Health Tracking Poll (2009). During 2009 the poll results indicated that 35% of respondents avoided doctors visits by utilizing over-the-counter medications or home remedies, 34% avoided dental care or check-ups, 27% postponed seeking needed health care, 23% opted to not get a doctor recommended test or treatment, 21% did not fill a prescription, 15% attempted to conserve medication by cutting pills in half or skipping doses, and 7% had difficulties obtaining mental health care (KFF, 2009).

With 25% of the U.S. population diagnosed with at least one of five chronic conditions (mood disorders, diabetes, heart disease, asthma, and hypertension) (Druss, Marcus, Olsen, et al., 2001), combined with the number of uninsured, the high cost of health care, and the many health care disparities present in America, it becomes clear why we need a major health care reform effort. A Democratic Senator from Montana recognized the need, stating:

In 2009, Congress must take up and act on meaningful health reform legislation that achieves coverage for all Americans while also addressing the underlying problems of our health care system. The urgency of this task has become undeniable... we all must realize that the costs of inaction, both in human and financial terms, will eventually be far greater than any initial outlays. We must choose to invest now in a health care system that will richly repay the nation with greater health and economic stability in the long term (Baucus, 2009, para. 3).

Components of the *PPACA*

Since its enactment, the *Patient Protection and Affordable Care Act* (Public Law 111-148) has already implemented the following changes to the U.S. health care system (implemented between March 23, 2010-July 1, 2011):

- Put health insurance information for consumers on the World Wide Web.
- Stopped denying health insurance access to children because of a pre-existing condition.
- Provided coverage options for adults who have been denied insurance coverage for at least six months because of a pre-existing condition.
- Allowed young adults to stay on their parents' insurance plan until they are 26 years.
- Made it illegal for insurance companies to deny coverage based on errors or technical mistakes on insurance applications.
- Stopped insurance companies from implementing lifetime and annual insurance limits.
- Established an external review process so consumers can make an appeal to their insurance company if they are unsatisfied with the coverage decision.
- Set up or expanded state programs to help consumers navigate the new law and health system.
- Made up to four million small businesses eligible for tax credits.
- Provided four million senior citizens who were part of the *Medicare* (Public Law 89-97) prescription “donut hole” with a tax-free \$250 rebate check.
- Offered prescription drug discounts to senior citizens.

- Established the Center for Medicare and Medicaid Innovation.
- Established the Community Care Transitions Program to help those on *Medicare* (Public Law 89-97) avoid unnecessary hospital readmissions.
- Began eliminating the gap between those enrolled in a traditional *Medicare* (Public Law 89-97) plan and those enrolled in *Medicare Advantage* (Public Law 89-97).
- Provided certain preventive services for free, such as mammograms and colonoscopies.
- Allocated \$15 billion to the Prevention and Public Health Fund to keep Americans healthy.
- Implemented provisions to reduce fraud and waste in *Medicare* (Public Law 89-97), *Medicaid* (Public Law 89-97), and *CHIP* (Public Law 111-3).
- Implemented incentives to increase the number of primary care doctors, nurses, and physician's assistants.
- Required insurance companies to provide an explanation for each premium increase.
- Allowed states to receive federal matching funds to insure more people on *Medicaid* (Public Law 89-97).
- Provided higher salaries for rural health care providers.
- Funded expansion and construction of community health centers across America.
- Began requiring that insurance premium dollars (at least 80-85%) are spent on health care.
- Began allocating funds for the Independent Payment Advisory Board to aid in the sustainability of Medicare Trust Fund.

- Allowed states to offer health care services through *Medicaid* (Public Law 89-97) instead of nursing home or institutional care (USDHHS, 2010).

See Table 4 for components of the *PPACA* (Public Law 111-148) that will be implemented from 2012 to 2015.

Table 4

Components of the Patient Protection and Affordable Care Act, 2012-2015

2012	Establishing value-based purchasing program
	Establishing accountable care organizations
	Streamlining administration costs
	Identifying and reducing health disparities
	Establishing new, voluntary, long-term care insurance plans
2013	Improving preventive health insurance coverage
	Providing higher authority to bundle payments
	Increasing Medicaid (Public Law 89-97) payments for primary care physicians
	Increasing funding for Child Health Insurance Programs
2014	Eliminating discrimination for pre-existing conditions and gender
	Eliminating annual limits on insurance coverage
	Covering participants in clinical trials
	Offering tax credits to make health care more affordable
	Establishing health insurance exchanges
	Increasing small business tax credits
	Increasing access to Medicaid (Public Law 89-97)

Table 4

Components of the Patient Protection and Affordable Care Act, 2012-2015 cont.

	Enforcing the individual mandate
2015	Paying physicians based on value, not volume

Note. Table referencing data from USDHHS (2010)

In addition to the provisions of the *PPACA* (Public Law 111-148), the law develops and expands upon four initiatives – Partnership for Patients: Better Care, Lower Costs; Stopping Medicare Fraud; Community Health Centers; and Improving Health Care Through Health Information Technology. The Partnership for Patients: Better Care, Lower Costs is an initiative to prevent injury and sickness and promote patient healing without complications to reduce hospital readmissions because medical mistakes are prevalent in the U.S. health care system. To achieve these goals, those who implement the *PPACA* (Public Law 111-148) will devote one billion dollars in an effort to develop a sustainable health care system that can save up to \$35 billion (USDHHS, 2011).

The Stopping Medicare Fraud initiative was established to keep waste, fraud, and abuse in Medicare from happening. Examples of *Medicare* (Public Law 89-97) fraud include health care professionals billing *Medicare* (Public Law 89-97) for services or equipment a patient never received, a person using another's *Medicare* (Public Law 89-97) card to receive health care services, and someone providing faulty information to persuade a consumer to join their *Medicare* (Public Law 89-97) plan (USDHHS & USDOJ, N.D.). To implement this initiative, President Obama, through the *PPACA* (Public Law 111-148), will allocate \$350 million dollars over ten years in an attempt to reduce *Medicare* (Public Law 89-97) fraud by 50% (USDHHS, 2010).

President Obama, in implementing the *PPACA* (Public Law 111-148), will also allocate \$11 billion over ten years to aid existing community health centers (there are currently 7,900) and build new community health centers so they can provide health care access to 20 million Americans who are currently without access (USDHHS, 2010). These community health centers are located in areas with a high need for health care services; they are governed by a community board primarily composed of community health center patients; they provide primary health care that is comprehensive in nature; they provide services to everyone including low income citizens, the uninsured, English as a second language citizens, migrant workers, the homeless, and citizens living in public housing; and they are held accountable to performance standards (HRSA, N.D.).

Finally, the Improving Health Care through Health Information Technology initiative is funded by the *American Recovery and Reinvestment Act* (Public Law 111-5; \$20 billion in five years), but the goals of this initiative are also goals of the *PPACA* (Public Law 111-148). They include improving quality of health care, preventing medical errors, decreasing paperwork, and decreasing costs (USDHHS, 2010). According to the Office of the National Coordinator for Health Information Technology (2011), health information technology allows health care professionals to always have accurate, complete patient records, to better coordinate care with other health care professionals through the use of electronic medical records, to share health information via the World Wide Web with patients and family members, to aid doctors in quicker diagnoses, to reduce medical errors, and to lower costs (Office of the National Coordinator for Health Information Technology, 2011).

Major Stakeholders in Health Care Reform

There are many different stakeholders with differing vested interests in the debate on health care reform. Much like the AMA did in America's earliest attempts at health care reform (KFF,

2009; PBS, 2010; Quadagno, 2006), many stakeholders have a vested interest in stopping health care reform policy efforts. On the other hand, there are many stakeholders who want to see health care reform policy efforts succeed. Literature suggests six major groups of stakeholders, some supporting and some opposing health care reform (Feldstein, 2007; Shi & Singh, 2008).

Federal and state governments are one of the major groups of stakeholders that have a vested interest in keeping government expenditures low and affordable, including health care expenditures (Feldstein, 2007). The government also wants to gain or maintain benefits for groups of citizens while reducing the cost of providing the benefits (Shi & Singh, 2008). Achieving this feat allows the government to keep costs down while gaining public support to enhance career longevity for politicians. However, this is difficult to accomplish because oftentimes expenditures exceed projected costs, much like *Medicare* (Public Law 89-97). In essence, every administration, whether it be Democrats who often support spending on social issues like health care or Republicans who often believe social programs should be cut out, faces difficult political choices (Feldstein, 2007).

Interests of the government are often competing with interests of another major group of stakeholders – hospitals and physicians (Feldstein, 2007). Many physicians want to maximize their income and have total control over their medical practice. What most physicians don't want is a government run health care plan that sets prices for medical treatments and procedures (Shi & Singh, 2008). On the other hand, a large portion of a physician's profits come from *Medicare* (Public Law 89-97) and *Medicaid* (Public Law 89-97) reimbursements. While physicians and hospitals wouldn't want government programs such as *Medicare* (Public Law 89-97) and *Medicaid* (Public Law 89-97) to be eliminated, their primary goal is to maximize profits, or increase medical expenditures (Feldstein, 2007). During the debates preceding the passage of

the *PPACA* (Public Law 111-148), the Obama administration negotiated with hospitals to get them to give up \$155 billion in government reimbursements [for *Medicare* (Public Law 89-97), *Medicaid* (Public Law 89-97), and other government-run programs] in ten years (Washington Post, 2010).

Increasing medical expenditures may be a good thing for physicians and hospitals, but it is definitely not good for employers and unions. This group of stakeholders' primary interest lies in decreasing the costs of their employees' insurance plans (Feldstein, 2007). Large employers want a health insurance plan for their employees offering low premiums and minimal costs. From 2000-2010 employer premiums have doubled, which reduces the amount of money owners can spend improving their business (USDHHS, 2010). Small employers also want a health insurance plan for their employees offering low premiums and minimal costs, but they, on average, spend 18% more on the same insurance plan than their large employer counterpart (USDHHS, 2010). Therefore, a national health care reform plan that reduces the rate of medical expenditures will benefit employers and unions (Feldstein, 2007).

Another group with vested interest in the success of health care reform is insurance, pharmaceutical, and medical equipment companies. Insurance companies are interested in obtaining and maintaining a large share of the insurance market. Pharmaceutical companies want to continue to profit from Americans purchasing medications, and medical equipment companies have the same goal with regard to the medical supplies they sell (Shi & Singh, 2008). The bottom line of this group of stakeholders is to have autonomy and not be under the control of any government agency or policy (Feldstein, 2007). These companies flourish when they can control their business practices, compete for market share, and raise or lower prices as they see fit. Also during the debates preceding the passage of the *PPACA* (Public Law 111-148), the

Obama administration negotiated with pharmaceutical companies to get them to forgo \$80 billion in government funds in 10 years for a *Medicare* (Public Law 89-97) prescription savings plan that gave total recognition to the pharmaceutical companies (Washington Post, 2010).

The next group of stakeholders has much influence on the success or failure of health care reform. This group is the middle class. At one point in time, the middle class was benefitting from employer-paid health insurance premiums as the premiums did not visibly lower their salaries. Now, however, rising health care premium rates are causing the middle class to have to choose more restrictive, expensive insurance plans. Therefore, because they are a large group of voters with a great deal of political power, their unhappiness with the current health care system plays a large role in the success or failure of health care reform (Feldstein, 2007).

A final group of stakeholders is the elderly population enrolled in or eligible for *Medicare* (Public Law 89-97). The *PPACA* (Public Law 111-148) includes many components that will affect the elderly including rebates and discounts on prescription drugs when entering the “donut hole,” free preventive services, eliminated *Medicare Advantage* (Public Law 89-97) overpayments to insurance companies, ensuring choice of physician, and coordinated care done in a team approach to better manage chronic conditions (CMS, 2010). There are many elderly people, especially those enrolled in *Medicare Advantage* (Public Law 89-97), who are worried that the *PPACA* (Public Law 111-148) will take away some of their insurance benefits.

In addition to the previously described stakeholders, the *PPACA* (Public Law 111-148) also focuses its programs and initiatives on four other groups who have a vested interest in the success or failure of the *PPACA* (Public Law 111-148) – families with children, individuals, people with disabilities, and young adults. For families with children and people with disabilities, the health care reform policy should increase their options for affordable, quality

health insurance plans (USDHHS, 2010). Individuals want to receive quality care at minimal cost. To help them reach this goal, the *PPACA* (Public Law 111-148) will not allow insurance companies to deny anyone insurance coverage because of an illness. It gives people the right to appeal insurance claim decisions. It allows women to choose any primary care physician, OB-GYN, or pediatrician, and it does not allow insurance companies to charge women higher premiums based on their gender (USDHHS, 2010). For young adults, the *PPACA* (Public Law 111-148) is extending the opportunity to stay on a parents' insurance plan until age 26 (USDHHS, 2010).

Whatever health care reform policy gets promoted in the U.S., it is imperative that reformers (including health educators advocating for policy change) take into consideration the differing vested interests of these major stakeholders because they are likely to voice their opinions in a way that promotes their agenda and influences the future of the policy. As President Obama knew that the pharmaceutical and insurance companies, and hospitals and physicians could use their forces to stop the passage of the *PPACA* (Public Law 111-148; Washington Post, 2010), so, too, should all others who want to make a difference in the health care system today.

Research on Health Care Reform

Public Opinion

Political issues, talking points, and debates are oftentimes based on current public opinions (Brodie, et. al., 2010), so it makes sense to analyze public opinion in relation to health care policies. The two most recent health care policies are the *PPACA* (Public Law 111-148), passed in 2010, and the Clinton administration's health care proposal of 1994. Research on public opinion suggests there is little difference in the public's opinion at the time each of these proposals was being debated (Brodie, et. al., 2010; Gelman, Lee, & Ghitza, 2010; Shapiro &

Arrow, 2009). Further, Brodie, et. al. (2010) suggests there are commonalities in public opinion regarding health care reform since 1943, but especially in the 1990s and 2000s. One commonality is the lack of trust in the government. Just before the *PPACA* (Public Law 111-148) passed in 2010, only 19% of Americans trusted their government (CBS News, 2010) while 23% of Americans felt trust in their government during the health care reform debates of the Clinton administration (Blendon, Brodie, & Benson, 1995). Aside from trust in government being very low, Americans during both health care reform debates found other issues to be more important than health care reform (although health care reform was ranked as an important issue during both time periods; Brodie, et. al., 2010; CBS News, 2010; Jones, 2010). After President Obama was elected in 2008, health care ranked third on the list of important issues, following the economy and terrorism (KFF, 2008). After President Clinton was elected in 1992, health care also ranked third on the list of important issues, following the economy and the federal deficit (Mitofsky, 1994). Not surprisingly, another commonality in public opinion during the Obama and the Clinton health care reform debates was the fact that Republicans are least likely to think the health care system needs modified or improved (Blendon, Brodie, & Benson, 1995). Lack of knowledge about the facts is yet another common characteristic between the debates over health care reform since the 1990s. During both health care reform debates, the majority of Americans believed that most uninsured people in the U.S. were unemployed, which was a false belief each time (KFF, 1994; KFF, 2003; KFF, 2007). Also, since the 1994 health care reform debates during the Clinton administration, Americans have been reporting that they are satisfied with their health insurance plans, but they have also been reporting problems with their health care such as not being able to afford insurance premiums and being fearful of losing their health insurance coverage (Brodie, et. al., 2010). The American people also have become more fearful

of reform efforts negatively impacting themselves and their families as the debates develop. The percentage of people believing health care reform to have a negative effect on themselves and their families raised as both the Clinton administration (from 21% in 1993 to 40% in 1994) and the Obama administration (from 11% in 2008 to 32% in 2010) pushed for reform policy (Gallup, 1994; KFF, 2010). A final commonality in public opinion during the various debates on health care reform is the fact that Americans say they want to improve access to health care for the uninsured, but they do not want to have to pay any more money to do so; in other words, the public is unwilling to sacrifice for those most in need (Brodie, et. al., 2010).

Additional facets of public opinion during the most recent health care reform debates deserve a close look as well, especially since the *PPACA* (Public Law 111-148) is the only major health care policy to pass into law since *Medicare* (Public Law 89-97) and *Medicaid* (Public Law 89-97) succeeded in 1965 (KFF, 2009). Shortly after the *PPACA* (Public Law 111-148) passed into law, researchers at the Brookings Institute (2009) conducted a survey of 800 Americans to assess their opinion about the health care system in America (Kull, Galston, & Ramsay, 2009). Their results yielded important information about public opinion on health care reform including the government's responsibility to ensure health for its people, the government's success in controlling the health care system, and health care as a right or privilege. When asked, "should the government be responsible for ensuring that its citizens can meet their basic need for health care," 60% said they believed it was the government's responsibility (Kull, Galston, & Ramsay, 2009). Another survey item stated, "keeping in mind the limits of the U.S. government's resources, please tell me how well the government is ensuring that people can meet the basic need for health care" ((Kull, Galston, & Ramsay, 2009). Sixty-six percent of respondents gave an answer of "not very well" or "not very well at all" to this question. Further, when asked, "do

you mostly think of health care as a right or as a privilege,” 63% responded health care is a right (although this belief was highly divided along party lines) (Kull, Galston, & Ramsay, 2009).

A more recent look at the polls may reveal even more about public opinion regarding health care reform. In January 2011, a Rasmussen Poll of 1,000 Americans found 53% (with responses ranging from 50-63% since March, 2010) of voters favoring repeal of the *PPACA* (Public Law 111-148; Rasmussen, 2011). The poll also found that 34% of respondents said it was at least somewhat likely they will be forced to change their health insurance coverage. Seventy-seven percent of respondents believed their health insurance coverage was good or excellent, and 48% (with responses ranging from the high 40s to low 50s since March, 2010) believed the *PPACA* (Public Law 111-148) will be good for the country (Rasmussen, 2011). While these statistics do provide insight on public opinion regarding health care reform, it is important to note as Brodie et. al. (2010) did about the differences in public opinion polls across time:

...the news media reported on how polls ticked up and down in the health reform “horse race,” giving the impression that public opinion was fluid. However, fluctuations observed during this debate didn’t reflect fundamental shifts in public views on health reform as much as they reflected different dynamics of public opinion rising to the surface as the debate ebbed and flowed (Brodie et. al., 2010, p. 1125).

Health Care Reform Opinions/ Recommendations from Other Professions

In addition to public opinion research, an in-depth examination of position papers on health care reform from various professions provide yet another perspective on the issue. These position papers come from physicians’ groups (American Academy of Family Physicians, 2011; American College of Physicians, 2011; Maves, 2010), employer groups (HR Policy Association,

2009), pharmaceutical companies (GlaxoSmithKline, 2009), and others (Arrow et. al., 2009; Robert Wood Johnson Foundation, 2009; TANC, 2009). While many of these groups had differing opinions and offered a wide variety of recommendations, there were a number of recommendations shared by multiple professions.

The most frequently offered recommendation by these professional groups was to expand access to health insurance coverage (American Academy of Family Physicians, 2011; American College of Physicians, 2011; Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009). This would be an essential reform because access to coverage improves the health of Americans (American Academy of Family Physicians, 2011). Not only would expansion of access improve the health of Americans, but it would also likely increase the global competitiveness of the U.S. (HR Policy Association, 2009). Other common recommendations made include containing costs, establishing and promoting Exchanges (which is a transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans; USDHHS, 2011), investing in health information technology (HIT), and promoting collaboration. Containing costs may be achieved by reducing administrative costs, focusing on prevention, paying based on quality of care or outcome measures instead of fee-for-service, or managing costs by all stakeholders (American Academy of Family Physicians, 2011; Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009). By establishing and promoting insurance Exchanges or basic coverage options, people who cannot afford or do not have access to group insurance plans will be able to have access to affordable insurance. Also, the Exchanges will help to protect the American public from the catastrophic financial burden from illness while promoting prevention (Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009; Maves, 2010). HIT includes

electronic medical records, electronic prescribing, messaging, etc. The benefits of HIT include a decrease in administrative costs, promotion of data exchange, promoting adherence to “best practices,” promoting prevention and treatment, and increasing quality of care (American Academy of Family Physicians, 2011; Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009). Promoting collaboration across fields and sectors is a recommendation to strengthen and improve the health care delivery system as a whole. The patient-centered medical home model is one way of improving collaborative efforts by using a team-based approach to medical care that provides preventive services, treatment, and end-of-life care (Arrow et. al., 2009; GlaxoSmithKline, 2009; RWJF, 2009).

There also were additional, less frequently offered recommendations made by multiple groups, and these recommendations mainly dealt with quality and cost. Promoting and offering flexibility and innovation for employers was one recommendation that relates to both quality and cost of health care. Employer freedom to develop health care plans for employees should promote cost-effective decisions from employees that leads to choosing the most effective treatment or preventive services (Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009). Another recommendation relating to quality and cost is the need for medical malpractice reform. Because malpractice lawsuits increase the cost of malpractice insurance and the practice of defensive medicine by physicians, reforms dealing with this issue should aid in reducing costs, increasing “best practice” medical techniques, and decreasing defensive medicine (American Academy of Family Physicians, 2011; GlaxoSmithKline, 2009; HR Policy Association, 2009). Allocating funds for public health, prevention, and chronic disease management also relates to quality and cost because a health care system that focuses on prevention will reduce costs related to untreated illness and lack of productivity and improve

health care outcomes and quality of life of individuals (American College of Physicians, 2011; Arrow et. al., 2009; GlaxoSmithKline, 2009; RWJF, 2009). Other recommendations related to quality and cost are establishing oversight boards and investing in research. Oversight boards increase quality of care because they can determine and update standards, and also oversee practices of physicians treating patients enrolled in programs such as *Medicare* (Public Law 89-97). (Arrow et. al., 2009; HR Policy Association, 2009). Investment in research related to comparative effectiveness of drugs, medical devices, and interventions also should lead to an increase in quality, cost, and effectiveness of health care (Arrow et. al., 2009; HR Policy Association, 2009). Finally, a recommendation related to health care quality and cost is reforming the *Medicare* (Public Law 89-97) and *Medicaid* (Public Law 89-97) payment systems. A reform that emphasizes physician payment based on cost and quality of the chosen medical treatment, rather than being based solely on cost, will improve patient care and make physicians accountable for their decisions (GlaxoSmithKline, 2009; HR Policy Association, 2009).

Health Education and Policy Involvement/ Advocacy

Limited research has been conducted regarding policy involvement in the field of health education. In fact, I could only find two articles relating to the topic (Cooper, 1986; Holtrop, Price, & Boardley, 2000). Authors of both articles emphasized the need for health educators to be involved in policy activities, and each recognized targeting health policies as being more effective in achieving behavior change than targeting individuals (Cooper, 1986; Holtrop, Price, & Boardley, 2000). Holtrop, Price, and Boardley (1986) identified numerous policy activities that could aid health educators in improving the health of individuals, families, and communities. The activities include identifying sources of information, communicating policy-related information, developing advocacy roles, and seeking political office (Holtrop, Price, & Boardley,

2000; Miner & Baker, 1993; Rohwer, 1991; Schmid, Pratt, & Howze, 1995; Steckler & Dawson, 1982). Cooper (1986) stated in her article:

Health educators are well suited for providing information to legislators on how proposed or existing governmental policies impact the public's health. Regardless of whether health educators practice in the school or community, they have been trained to know what is required for the promotion of healthy individuals, healthy communities, and a healthy society (Cooper, 1986, p. 10).

Cooper's (1986) research study involved surveying a sample of health education undergraduate students to determine their level of political involvement and to assess their attitudes regarding political participation. While this study was a first step, Holtrop, Price, and Boardley (2000) went a step further to survey a much larger sample of practicing health educators in professional organizations and health educators with CHES certification. Their survey measured policy involvement, policy knowledge, policy interest, policy exposure, perceived barriers to policy involvement, and self-efficacy to be involved in policy activities.

Results of both studies found that health educators were involved in policy activities, but the involvement was minimal and could be greatly improved (Cooper, 1986; Holtrop, Price, & Boardley, 2000). The 1986 study revealed that only seven percent of participants could name their senator, 11.4% could name their assembly member, and 21.1% could correctly name their lieutenant governor (Cooper, 1986). The same participants also reported a number of other behaviors. Over 80% of participants were registered to vote, and over 80% reported planning to vote in the next election. Also, approximately half of the participants reported communicating with an elected official about a topic of importance to them. However, almost half of the participants surveyed reported an attitude of "why bother to get involved; I know I can't make a

difference” (Cooper, 1986). The results of this study indicated a need for increased political awareness.

Based on these two studies, little changed regarding political activities of health educators from 1986 to 2000. Holtrop, Price, and Boardley (2000) found that 36% of health educators surveyed participated in two or fewer policy activities in the previous two years (the mean score for policy activities was 4.84). The most common policy activities reported were voting (86.2%), contacting a public official (64.9%), providing policy-related information (59.0%), and working on a coalition (50%) (Holtrop, Price, & Boardley, 2000). Nearly all of the participants (98.0%) reported barriers to policy activity. The most frequently reported barriers were lack of time (69.4%), other priorities (43.3%), and frustration with the process (39.0%) (Holtrop, Price, & Boardley, 2000). Additionally, participants of this study reported being somewhat interested in influencing policy decisions, and they reported a belief that policies do indeed influence the health of the public (Holtrop, Price, & Boardley, 2000). If health educators aren't very interested or involved in policy activities, what is being done to increase involvement and interest?

One way of increasing involvement and interest among health educators regarding policy is to join policy-related workgroups or attend summits and conferences framed around policy issues. Each year since 1998 the Coalition of National Health Education Organizations (CNHEO) sponsors an Advocacy Summit in Washington D.C. At the summit, health educators meet with legislators, participate in various health issue updates, and are provided with advocacy training to better enable them to become active in the health policy arena (Capwell, 2004; Health Education Advocate, 2011). In addition, health educators can become more involved in advocacy activities. A California politician spoke about the need for advocacy in public health:

When you look back on key legislative fights over public health issues, you will see that the expertise and advocacy of public health professionals provide a critically important counter pressure to the lobbying clout of special interests. The grassroots efforts by the public health community help educate legislators and play a pivotal role in our legislative efforts to improve the health of the people of the United States (APHA, 1999, p. 1).

There are also advocacy work groups for health educators to join through various professional organizations. The American Association for Health Education (AAHE) sponsors a campaign called Health Education Action Link (HEAL) that is devoted to connecting AAHE members with legislators when the government is considering a health education legislation (AAHPERD, 2011). The American School Health Association (ASHA) members also devote some of their actions to policy and advocacy (the ASHA Advocacy Network). These advocacy actions are similar to HEAL in that they alert members when school health education legislation is being considered so members can contact their legislators (ASHA, 2011). ASHA leaders also organize various advocacy coalitions including the Coalition for Healthier Schools, the Community Anti-Drug Coalitions of America, Friends of School Health, the National Alliance for Nutrition and Activity, Friends of CDC, Friends of HRSA, Research and Prevention, and Tobacco Free Kids (ASHA, 2011).

In addition, health educators can work to be an influential interest group in the area of health care reform. In fact, Heaney (2004) stated that the American Public Health Association (APHA) and the American School Health Association (ASHA) were two of the most active groups on health care advocacy from 1997-2002.

Interest groups provide information and campaign support to elected officials and use several strategies to influence policy, including direct lobbying, grassroots organizing, campaign

contributions through PACs [political action committees], and participation in coalitions... In sum, the role of interest groups in defining and shaping health care policy is pivotal. Next to Congress, interest groups may well be the most important actors in health policy (Weissert & Weissert, 2006, pp. 132-133).

Interest groups spend much of their time researching and gathering information and data about the health problem and impact of the health policy to share with the public and their supporters (Weissert & Weissert, 2006). Along with obtaining and distributing information, gaining access to politicians or key influentials is equally important for interest groups as they influence health care policy. Members of interest groups who have 15 minutes with a politician and a well-framed stance on health care policy have the ability to change that politician's opinion about the issue, and thus change outcome of the particular health care policy debate (Weissert & Weissert, 2006). Finally, it is important for interest groups to use the media to get their message dispersed. During the 1993 health care reform debates, \$60 million was spent on television campaigning; including the famous Harry and Louise commercials that questioned the Clinton health care plan (Seelye, 1994). Today, the Internet is also an important venue for getting health and political messages out to the masses. Interest groups are using the Internet disperse messages, mobilize supporters, raise money, and encourage grassroots activism (Bosso & Collins, 2002).

Finally, it is important to mention that one of the seven areas of responsibility for health educators as defined by NCHEC is to "communicate and advocate for health and health education" (NCHEC, 2008, Responsibilities and competencies of health educators section, para. 37). The responsibility to "communicate and advocate for health and health education" requires health educators not only to analyze and respond to health needs, but to promote the profession and influence health policies in a way that promotes health (NCHEC, 2008). This includes

influencing health policies like the *PPACA* (Public Law 111-148). The recommendations made as a result of this study can be used to influence policymakers in Washington D.C. as they continue their endeavor to put in place an effective and accepted health care reform policy.

Health Education and Health Care Reform/ *PPACA*

Not only does the health education profession have the responsibility to “communicate and advocate for health and health education” (NCHEC, 2008, Responsibilities and competencies of health educators section, para. 37) including influencing health policy like the *PPACA* (Public Law 111-148) and other health reform policies (NCHEC, 2008), but they also have an ethical responsibility to do so. The health education code of ethics states:

The health education profession is dedicated to excellence in the practice of promoting individual, family, organizational, and community health. The Code of Ethics provides a basis of shared values that health educators have practiced. The responsibility of all health educators is to aspire to the highest possible standards of conduct and encourage the ethical behavior of all those with whom they work (NCHEC, 2000, para. 1).

Additionally, the code of ethics specifies six articles, or responsibilities: responsibility to the public, responsibility to the profession, responsibility to employers, responsibility in the delivery of health education, responsibility in research and evaluation, and responsibility in professional preparation (NCHEC, 2000). In having the responsibility to the public:

A health educator’s ultimate responsibility is to educate people for the purpose of promoting, maintaining and improving individual, family and community health. When a conflict of issues arises among individuals, groups, organizations, agencies, or institutions, health educators must consider all issues and give priority to those that

promote wellness and quality of living through principles of self-determination and freedom of choice for the individual (NCHEC, 2000, para. 2).

The health care reform debate is a conflict of issues that has continued for a century, and it is an issue that affects all individuals, families, and communities. With a professional responsibility to influence health policy and an ethical responsibility to consider all issues and educate the public, it is essential that health educators closely consider the issues involving health care reform in the U.S. and influence the policy in a way that promotes the health of all individuals, families, and communities.

Another reason health educators need to be involved in the health care reform debate is the profession's longstanding efforts to achieve the nation's ten-year goals set forth by the USDHHS (*Healthy People* documents; 2011). Researchers at the USDHHS outline many goals within the topic area of access to health services, which relates directly to the current health care reform policy. The following are goals for access to health services:

- Increase the proportion of persons with health insurance.
- Increase the proportion of insured persons with coverage for clinical preventive services.
- Increase the proportion of persons with a usual primary care provider.
- Increase the number of practicing primary care providers.
- Increase the proportion of persons who have a specific source of ongoing care.
- Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.
- Increase the proportion of persons who receive appropriate evidence-based clinical preventive services.

- Increase the proportion of persons who have access to rapidly responding pre hospital emergency medical services.
- Reduce the proportion of hospital emergency room visits in which the wait time to see an emergency department clinician exceeds the recommended timeframe (USDHHS, 2011).

To achieve these goals health professionals (including health educators) must collaborate to develop the best possible strategy for achieving the goals, whether it be keeping the current *PPACA* (Public Law 111-148) or developing a new policy with different guidelines (USDHHS, 2011).

In order to thoroughly analyze the issue of health care reform, health educators must become educated on the topic. One way of doing this is to obtain continuing education units (CEUs) on health policy topics. Currently, there are five continuing education credit activities on the topic of health care reform (NCHEC, 2011). These continuing education credit activities offer a means for health educators to maintain their CHES/MCHES certification (all CHES and MCHES health educators must obtain a minimum of 75 continuing education credits during the five year certification period; NCHEC, 2011), and the health care reform activities currently being offered are online courses. The courses offer a way for health educators to become effective resource persons on health care reform, to learn how to help children and families obtain health insurance, and to learn how being uninsured relates to public health (NCHEC, 2011).

It may also be necessary for health educators to learn how the *PPACA* (Public Law 111-148) can help them in their effort to improve the health status of the American public. Title IV of the *PPACA* (Public Law 111-148) is aimed at improving population health through prevention (Davis & Somers, 2011). Health educators can work with the National Prevention, Health

Promotion, and Public Health Council (funded by the *PPACA*; Public Law 111-148) to provide recommendations to the Congress and President Obama regarding evidence-based strategies to increase prevention, wellness, and health promotion (42 U.S.C.A., 2010). Health educators can also apply for funding through the \$250 million allocated by the *PPACA*'s (Public Law 111-148) Public Health Fund, which was created to boost clinical and prevention initiatives such as anti-obesity programs and public health research (USDHHS, 2010). Title IV of the *PPACA* (Public Law 111-148) also funds a number of provisions including requiring chain restaurants to post nutrition information about their products, mandating employers to provide times and places for mothers to nurse, researching and treating depressive disorders, establishing a partnership to provide public health education about health promotion and disease prevention, and raising awareness about breast cancer (Davis & Somers, 2011). Health educators would be wise to join in on the government's quest to increase health status of U.S. citizens. Not only would it be an effective use of resources and collaboration, but it would also be a good way to obtain funding to carry out health education activities that are already taking place.

Think Tanks and Health Care Policies

A think tank is "an institute, corporation, or group organized for interdisciplinary research such as technological or social problems" (Merriam-Webster Dictionary, 2011, Think tank definition section, para. 1). According to Peters (2008), there are five major think tanks in the United States today that play a major role in policy research: the Brookings Institute, the Cato Institute, the Economic Policy Institute, the Heritage Foundation, and the National Center for Policy Analysis (Peters, 2008, pp 62-63). Each of these think tanks has conducted research on many policy issues, including health care reform.

Brookings Institute employees were hired during the Carter and Clinton administrations to conduct research on policy issues (Peters, 2008, p 63). In recent years the Brookings Institute has conducted research on health care reform, including a recent study on the deficit reduction plan in relation to health care reform (Patel, 2011). Among many other things, the study outlines how the *PPACA* (Public Law 111-148) should reduce the federal deficit by reducing waste and abuse in the system while strengthening regulations and enforcements; making the health care delivery system more efficient while maintaining safety and quality; and further analyzing *Medicaid* (Public Law 89-97) and *Children's Health Insurance Program* (Public Law 111-3) in relation to funding from both federal and state governments (Patel, 2011).

The Economic Policy Institute (EPI) is another think tank that has been conducting research related to health care reform. With much of their research on policies related to the influence of the economy, researchers at the EPI believe that the recession and the resultant poor labor market are having a negative impact on access to health care. Their research found that, while unemployment rose from 5.8% in 2008 to 9.3% in 2009, employer-based health insurance fell from 61.9% in 2008 to 58.9% in 2009 (Silag & Conner, 2010).

Another major think tank conducting research on health care reform is the Cato Institute. The Cato Institute takes a much different stance on health care reform than the previously described think tanks. Researchers at this think tank believe that health care reform goes against the Constitution to have a limited government. They state, "An essential aspect of liberty is the freedom not to participate. *PPACA's* (Public Law 111-148) directive that Americans buy an unwanted product from a private company debases individual liberty. And it's unconstitutional" (Levy, 2011, p. 1).

The Heritage Foundation is another think tank that became popular during the 1980s, and its employees support policies that promote privatization and deregulation (Peters, 2008, p 64). Those involved in research for the Heritage Foundation believe that health care in the U.S. is one of the most regulated sectors of the economy, and this in turn, gives Americans fewer personal freedoms. They do not agree with the *PPACA* (Public Law 111-148) and believe that individuals and families should be free to choose their own health care plans without assistance from the government (Heritage Foundation, 2011).

A final major think tank conducting research on health care reform is the National Center for Policy Analysis. Employees working for this think tank also disagree with the *PPACA* (Public Law 111-148), and they believe there are structural flaws with the act. They disagree with the individual mandate, the idea of subsidies, incentives for insurers, incentives for individuals, and they think insuring 32 million currently uninsured Americans is an unreachable goal (NCPA, 2011).

Researchers at the five major think tanks have very different angles and stances from which they conduct research (and they often illustrate their opinions rather than maintaining objectivity by simply stating the results of their research), as illustrated above. Additionally, health educators may also prove to be another think tank with a valuable input to provide. The profession, with a vested interest in the health of the population and an emphasis on prevention, can offer creative and innovative recommendations for health care reform policy, just as think tanks are expected to do (Peters, 2008, p 63).

Theoretical Framework

The theoretical framework for this study is that of the *Healthy People 2020* determinants of health ecological model (USDHHS, 2011). The model is comprised of five determinants of

health, each of which interacts together and influences the health status of individuals, communities, and society. The five determinants are biology and genetics, individual behavior, health services, social factors, and policy making (USDHHS, 2011).

Health educators typically develop interventions or programs that target primarily individual level behaviors (Holtrop, Price, & Boardley, 2000 & Freudenberg, 2006). However, the large number of individual level behavioral interventions that have failed to improve the health status of participants illustrates the need to think of health education on a broader scale (Schneider & Stokols, 2009). Freudenberg (2006) speaks of why it is important to think about health issues from an ecological approach:

The major causes of death today are heart disease, cancer, stroke, accidents, and violence. Each of these conditions is firmly rooted in our country's social structure. To address only the behavioral manifestations of our social ills, without touching their political and economic determinants, is like treating the symptoms of cancer as the tumor grows...if one defines health education more broadly – as those efforts that educate and mobilize people to create more healthful environments, institutions and policies (as well as lifestyles) – one can find a rich tradition of health education for social change (Freudenberg, 2006, p. 65).

A commonly utilized ecological model in health education is the social ecological model (SEM) (McLeroy, Bibeau, Steckler, & Glanz, 1988). This model is also based on five levels, but the levels are slightly different from the *Healthy People 2020* determinants of health ecological model. The SEM model is comprised of the following levels for which to target during interventions: intrapersonal, interpersonal, institutional, community, and society (McLeroy, Bibeau, Steckler, & Glanz, 1988). While this model is the most widely accepted ecological

model in the field of health education, I chose to utilize the *Healthy People 2020* determinants of health ecological model for two reasons: 1) the latter model is currently being promoted and used within the federal government to achieve the *Healthy People 2020* goals and objectives for the decade, so it is more likely to be an accepted model for the government to use when thinking about health care reform issues; and 2) the health services and policy making levels of the *Healthy People 2020* determinants of health ecological model encompass many attributes that can be directly related to health care reform issues.

According to the USDHHS (*Healthy People 2020* document; 2011), policy making includes “policies at the local, state, and federal level that affect individual and population health.” The *PPACA* (Public Law 111-148), along with other health care reform policies, is a federal policy to be implemented by all three levels of government, and it certainly affects individual level health by providing increased access to health insurance, by possibly increasing or decreasing insurance premiums for some individuals, etc. The law also affects population level health because it has the ability to lower, or maybe even raise, the federal deficit which will in turn lower or raise inflation, taxes, etc. It also affects population health through its implementation of certain laws and regulations (such as the individual mandate) that populations as a whole have to follow.

Social factors are:

Social and physical determinants of health that reflect the social factors and the physical conditions in the environment in which people are born, live, learn, play, work and age....they impact a wide range of health, functioning and quality of life outcomes (USDHHS, 2011, Social section, para. 1).

Social determinants in relation to health care include:

- Availability of resources to meet daily needs, such as opportunities for accessing health insurance and health care.
- Social norms and attitudes about health care, such as who should receive treatment and at what cost to them and to society.
- Social support and social interactions of different groups both supporting and opposing health care reform.
- Exposure to mass media and emerging technologies, such as marketing messages telling consumers the “best” treatment options, or media messages describing why health care reform is unconstitutional or, on the flip side, necessary.
- Socioeconomic conditions, such as concentrated poverty causing some people to have limited or no access to health care.
- Quality hospitals, clinics, or health centers.
- Transportation options to and from health centers (USDHHS, 2011).

Physical determinants in relation to health care include:

- Natural environment, such as weather or climate change that may affect health care access or options.
- Built environment, such as health care building locations and transportation systems.
- Worksites and health care settings.
- Housing, homes, and neighborhoods.
- Exposure to harmful substances that affects need for health care.
- Physical barriers to health care, such as people with disabilities (USDHHS, 2011).

Health services is another level of the *Healthy People 2020* determinants of health ecological model because both access to and quality of health services can impact health. According to the Agency for Healthcare Research and Quality (2008),

Lack of access, or limited access, to health services greatly impacts an individual's health status. For example, when individuals do not have health insurance, they are less likely to participate in preventive care and are more likely to delay medical treatment (AHRQ, 2008, para. 2).

Potential barriers to accessing needed health services are lack of availability, high cost of insurance premiums or out-of-pocket expenses, or lack of insurance coverage. Presence of barriers to health services can eventually lead to unmet health care needs, delays in treatment or care, not being able to receive needed or recommended preventive services, and even hospitalizations (USDHHS, 2011).

Individual behaviors is another level of the *Healthy People 2020* determinants of health ecological model. Although many interventions focusing on only individual level behaviors have proven to be ineffective (Schneider & Stokols, 2009), individual level behavior changes can affect health outcomes. For example, if a person starts exercising and eating healthy, their chance of developing type II diabetes and high blood pressure decrease. Other examples of individual behavior changes that affect health are consuming alcohol, tobacco, or other drugs, wearing a seatbelt, getting vaccinated, etc.

The final level of the *Healthy People 2020* determinants of health ecological model is biology and genetics. Biology and genetics are important to consider because they too affect health status. For example, having a family history of asthma increases one's chances of

developing asthma. Biology and genetics can also be thought of in terms of determinants of health. For example:

Sickle cell disease is a genetic determinant of health. Sickle cell is a condition that people inherit when both parents carry the gene for sickle cell. The gene is most common in people with ancestors from West African countries, Mediterranean countries, South or Central American countries, Caribbean Islands, India, and Saudi Arabia (USDHHS, 2011, Biology and genetics section, para. 2).

Age, sex, genes/DNA, and family history are also genetic or biologic determinants of health that can impact someone's need for health care treatments and services.

According to the USDHHS (*Healthy People 2020* document; 2011), interrelationships among these determinants influence the health of individuals and communities; so targeting multiple determinants of health increases effectiveness – including health care reform. Interview questions attempted to bring forth ways in which the *PPACA* (Public Law 111-148; or other health care reform proposals) could target multiple determinants of health to improve the health care system/ access to health care and the health of American people.

Characteristics of Interest

The characteristics of interest for this study were being committed to health care reform, workplace setting, years of experience in the profession, and gender. I believed that health educators with differences in these characteristics were likely to provide different recommendations for health care reform. First and foremost, the sample of health educators selected to participate in this study needed to be committed to health care reform. As the researcher, I believed those health educators who were committed to health care reform would be better able to provide in-depth, thoughtful recommendations for health care reform and the

potential roles for health educators within the health care system. A commitment to health care reform was chosen as selection criteria over knowledge about health care reform because health educators may be able to provide recommendations for the health care system without having a great deal of knowledge about health care reform and without having studied health care reform issues. Workplace setting (community, medical, post-secondary, school, worksite, organization/foundation, and government), years of experience in the profession, and gender were characteristics of interest chosen based on the results of the Holtrop, Price, and Boardley study (2000). Their study revealed that there were no statistically significant differences in involvement of policy activities based on level of education and race/ethnicity. However, there were significant differences when looking at age, employment setting, and gender/sex. Basically, their study found that older health educators, male health educators, and health educators working in government settings were more likely to report involvement in policy activities. Further, those health educators working in government settings were more likely to be involved in policy activities in their work as a health educator (as opposed to being involved in policy activities for personal interest) than health educators working in other settings (Holtrop, Price, & Boardley, 2000). Although the current study did not focus on measuring policy activities of health educators, it was still thought to be of value to look for differences in recommendations of health educators in these different characteristic groups because their personal experiences and attitudes about policy certainly affected the types of recommendations they provided.

Furthermore, research on political knowledge indicates that males have a greater knowledge of national politics than do women. It also shows that those born during and before the “baby boom” era of 1946-1964 are also more knowledgeable about national politics than

those born after 1964 (Delli Carpini & Keeter, 1996). If knowledge about policy issues affects recommendations about policy issues, then it stood to reason that recommendations for health care reform might have varied by age and gender.

Online Chat Room Focus Groups

A focus group is an interview on a topic with a group of people who have knowledge about the topic (Krueger, 2008; Stewart, Shamdasani, & Rook, 2006). According to Merriam (2009), participants in focus groups should be purposefully selected as the people who know the most about the topic at hand, and the optimum number of people in a focus group should be between six and ten (Merriam, 2009). The current study purposefully sampled health educators who were committed to health care reform, and each focus group conducted was organized to comprise six to ten health educators of the same workplace setting. However, there were many focus groups held with less than six participants, as it was difficult to ensure attendance during each session.

An online focus group is the same as a regular focus group, except the participants and the facilitator are not face-to-face. They are having the interview or discussion about the topic via the Internet. Although online focus groups are becoming more popular and more commonly used as a method of data collection (Schneider et. al., 2002; Wyatt & Williams, 2004), there are still many researchers who believe that nothing can replace a face-to-face focus group (Silverman, 2000). Following, are some of the reasons why a researcher would not conduct an online focus group:

- It is difficult, and sometimes impossible to create group dynamics.
- Nonverbal communication is missed unless video-streaming technology is utilized.

- Security and anonymity are hard to accomplish because there is no real way to know who is sitting at each computer during the focus group session.
- The facilitator can never be sure that participants are paying attention during the focus group.
- The facilitator's job may be more difficult because he/she is not receiving feedback from nonverbal cues and group dynamics (McDaniel & Gates, 2002).

Despite all of the drawbacks to online focus groups, there are many advantages and reasons to use them as a means of data collection. Listed are some of the advantages of online focus groups:

- They are less expensive.
- They can be organized and conducted in a short period of time because travel is no longer an issue.
- A more diverse group of participants can be reached because anyone, anywhere can participate without having to meet in one physical location.
- The participants may feel more open to share their feelings in writing, especially shy participants.
- Word-for-word transcripts are available for analysis almost immediately.
- The facilitator may find it easier to moderate discussion as he/she doesn't have to think and react as quickly (McDaniel & Gates, 2002; Silverman, 2000).

Other research on online focus groups has shown that online participants usually contribute shorter comments that are more uniform in level of participation, while some participants in the face-to-face focus groups dominate the conversation (Schneider et. al., 2002). I believed that the benefits of being able to reach a diverse group of health educators from all over the United States

outweighed the disadvantages of conducting online focus groups. Therefore, the study was conducted via means of synchronous online focus groups where participants purposefully selected for the study were given a web address to visit during the allotted focus group time. They were assigned code names to enable them to remain anonymous, and they were able to discuss the issue of health care reform with other health educators from around the country.

Summary

Chapter 2 presented a review of literature related to health care reform and its relation to the profession of health education. Discussion included a history of health care reform efforts, current need for reform today, and the major stakeholders of health care reform. It also included information on the limited research available regarding health educators and health care reform. This literature provided a framework of evidence about the relevance of health care policy to the health educator's set of professional skills and the opportunity for the profession act as a think tank in order to make recommendations for health care reform in relation to an ecological framework that recognizes the relationship between policy making, social factors, health services, individual behavior, and biology and genetics. Chapter three describes the methods for this study.

CHAPTER THREE

METHODS

Purpose of the Study

The primary purpose of this study was to explore recommendations from health educators for health care reform in relation to the different levels of the determinants of health ecological model. Additionally, this study examined the potential new roles participants identified as important for the health education profession in achieving an effective health care system.

Research Questions

- 1) From a health education perspective, what individual, health service, societal, and policy components should be in place for a successful health care reform plan to succeed?
- 2) What roles in health care reform do participants see as potential roles for health education professionals?
- 3) How do health educators advocate or act on policy issues related to access to health care/ health care reform?

Research Design

This qualitative study was based on an interpretivist research paradigm in which the ultimate aim was to understand and interpret. Qualitative research is defined as:

An umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world (Van Maanen, 1979, p. 520).

Merriam (2009) describes four characteristics of qualitative research to further explain its meaning. First, qualitative research focuses on meaning and understanding, which means

qualitative research is concerned with the meaning that participants give to their life experiences and also with how they interpret those life experiences. Second, the researcher is the primary data collection instrument in qualitative research, rather than a survey or questionnaire that is common in quantitative research. The qualitative researcher conducts interviews, observations, focus groups, etc., in which he/she can adapt to the environment and the context as well as modify the procedure as he/she deems necessary. Third, qualitative research is an inductive process that builds meaning, concepts, or theories rather than starting from a larger concept and trying to deduct a conclusion. Finally, qualitative research results are most often conveyed in the form of rich, thick description; meaning that words from the participants themselves are used to give meaning to the study and describe the phenomenon (Merriam, 2009, pp. 15-16).

With interpretivist research, knowledge is viewed as subjective, contextualized, value-laden, and specific (Lather and Pierre, 2006). The aim of this particular study was to gain contextualized, value-laden, specific knowledge from health educators to understand and interpret their responses about what needs to be in place on multiple levels for health care reform to be successful, including roles for health education professionals. The research methodology in this study was theory-driven, using the *Healthy People 2020* determinants of health ecological model (USDHHS, 2011). Determinants of health include biology and genetics, individual behavior, health services, social factors, and policy making. According to the USDHHS (*Healthy People 2020* document; 2011) interrelationships among these determinants influence the health of individuals and communities, so targeting multiple determinants of health increases effectiveness – including effectiveness of health care reform strategies/efforts. I framed discussion questions around the determinants of health to elicit input from health educators about what needs to be in place in each level for health care reform to be successful.

Sample

The sampling frame for this study was CHES and MCHES certified health educators who reported a commitment to health care reform. This sampling frame was selected because health educators all across the country working in different settings, with different degrees, of different genders, and with different years and types of work experience can become CHES or MCHES certified. Therefore, the results from this study produced opinions and recommendations from a cross section of health education professionals. Obtaining a representative sample of a particular population is not generally a major consideration of qualitative research. However, this study was unique in that qualitative data from health educators across settings may eventually serve as a position statement for the profession with which to influence health care reform. Maximum variation purposeful sampling was used to identify those health educators who represented a wide range of characteristics of interest (Merriam, 2009). The characteristics of interest are workplace setting (community, medical, post-secondary, school, worksite, and organization/foundation), years of experience in the profession, and gender. Basically, the sample consisted of health educators in six major workplace settings, where each workplace setting group is comprised of male and female health educators of varying years of experience in the field of health education. Maxwell (2007) states that this type of sampling strategy is a common sampling technique in qualitative research because it tends to increase the likelihood that results from the study will represent different perspectives (Maxwell, 2007), which was a goal of this study.

To obtain the sample of health educators, a list of all CHES and MCHES health educators was purchased from the National Commission for Health Education Credentialing, Inc. I sent a letter (see Appendix B) to the NCHCEC board to request approval to purchase and utilize the list

of CHES and MCHES certified health educators as the study population. Once permission was granted from NCHEC (see Appendix C) and internal human subjects approval was obtained (see Appendix A), I purchased the list. The list contained a total of 8,683 members, but 61 did not provide an email address and 235 email addresses did not work (and were removed from the list). A mass email in blind copy format was sent to the rest of the list (n= 8,387) to identify those health educators who reported a commitment to health care reform (Appendix D). Participants identified themselves as being committed to health care reform to be included in the study.

The recruitment email was sent only once over two weeks in order to obtain the potential study sample because a large number of health education specialists agreed to participate in the study. After the two-week recruitment period, I attempted to select study participants based on workplace setting, years of experience in the profession, and gender in order to obtain a sample of participants that represented all workplace settings, varying years in the profession, and both genders. The demographic information (workplace setting, years in the profession, and gender) used to select the study participants was thought to be available on the CHES and MCHES list, but the information on the list was not complete enough to gather. Therefore, once potential participants agreed to participate in the study and identified themselves as committed to health care reform, I was able to ask them via email about their workplace setting and gender in order to organize the focus groups (information about years of experience in health education was obtained during focus groups).

The focus groups were organized according to workplace setting. This process allowed for more homogeneous groups of health educators to discuss the topic of health care reform. I suspected that having homogeneity within the groups in the form of workplace setting would

result in different types of recommendations from the various groups. The final study sample received another email (see Appendix E) to let them know they had been selected to participate in the study, and to request they select a time frame (two or three were provided to them) that they would be available to attend the online focus group. Three time frames were provided to the community, post-secondary, and medical settings, as they were the workplace setting groups most largely represented. The study participants were able to select the focus group session that best accommodated their schedule, although some could not find an accommodating time. Six to ten participants in a particular workplace setting (the recommended number of subjects in a focus group according to Merriam [2009]) were the target number of participants for each time frame. The two to three time frames for each workplace setting comprised the first two to three sets of focus groups for that workplace setting, and if more than 20 to 30 participants per workplace setting had agreed to participate in the study, the first 20 to 30 to agree to participate would have been contacted to participate in the first two to three sets of focus groups while the remaining health educators would be contacted via email to inform them that the first sets of focus groups were already full, but they would be contacted to participate in three to four weeks if additional focus groups were needed.

According to Neutens and Rubinson (2010), the number of focus groups in a study can range from 6-50. As an incentive for participating in the focus groups, all participants were entered in a drawing where the winner received a prize of the entire *PPACA* (Public Law 111-148) along with four recently published books on health care reform (*Healthcare Disparities at the Crossroads with Healthcare Reform* (William, 2011), *Health Care Reform and American Politics: What Everyone Needs to Know* (Jacobs & Skopol, 2010), *Landmark: The Inside Story of America's New Health Care Law and What it Means for Us All* (Washington Post Staff,

2010), and *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform* (Starr, 2011).

Instrumentation

For this study, I used online focus group interview/ discussion questions to collect data, and I was also the primary instrument of data collection, meaning that I was the one actually gathering the data rather than a survey or other inanimate instrument (Creswell, 2007). A focus group is an interview on a specific topic with a group of people who have knowledge about that topic (Krueger, 2008; Stewart, Shamdasani, & Rook, 2006). Neutens and Rubinson (2010) speak about the nature of focus groups:

The sessions should be relaxed and the participants should be told that you are seeking interaction, not a question-answer format...Rather than ask each person in the group to respond to the same question, the researcher encourages participants to talk to each other – ask questions, give examples, provide comments. Focus groups arrive at opinions and can get to the reasons underlying those opinions (Neutens & Rubinson, 2010, p. 124).

In this particular study, focus group and interview questions attempted to bring forth ways in which the *PPACA* (Public Law 111-148; or other health care reform proposals) can target multiple determinants of health to improve the health care system/ access to health care and the health of American people. I utilized a semi-structured methodology for the focus groups and interviews, in which the interview guide contained a group of core questions related to the research questions, along with possible probing questions to enhance the discussion (see Appendix F). Merriam (2009) provides more detail about the interview guide and the process of facilitating discussion:

...the fewer, more open-ended your questions are the better. Having fewer broader questions unhooks you from the interview guide and enables you to really *listen* to what your participant has to share, which in turn enables you to better follow avenues of inquiry that will yield potentially rich contributions (Merriam, 2009, p. 104).

Based on this advice, I tried to utilize few, open-ended questions to elicit in-depth, rich discussion that allowed me to comprehend the meanings of the responses given by the focus group and interview participants.

The chat room focus group was piloted once with a group of 12 individuals and twice with 4-10 health education doctoral students from Southern Illinois University Carbondale before the study began. Piloting the focus groups allowed me to determine the optimum number of participants to include in each focus group and to work out any problems that occurred with the chat room software and the process (assigning code names to ensure anonymity, successfully moderating the focus groups, allowing sufficient time for each question, etc.). Because discussion was rushed preventing all questions from being answered with 12 participants, I chose the optimum number of participants to be between 4-9 people. The biggest change that occurred as a result of piloting was the decision to not moderate the focus groups. Moderating means I would have received all comments before anything was posted to the chat room wall. Thus, I would have controlled the order the comments were posted and the flow of conversation. Initially, I thought that moderating the focus groups would keep the discussion on topic, but all pilot study participants believed that moderating the focus group kept them from discussing openly with each other, therefore stunting conversation and slowing down the focus group itself.

Data Collection

Once subjects were selected for participation in the study, I emailed each participant a consent form (see Appendix G) explaining the nature of the study. The consent form also explained that I intended to ensure anonymity; but because the study was conducted via a focus group with multiple participants, each participant would also be privy to the information shared. For that reason, ensuring complete anonymity may be difficult. The participants were assigned a code name to use during the focus group, thereby increasing anonymity. I was, however, privy to the code names of the participants in order to contact the participants regarding the meaning of their responses (member checking), and this fact was disclosed within the consent form. Participants were also given the date and time of their scheduled focus group session along with the web link to visit at the time of the focus group.

Parachat® (see Appendix I for a screen print of Parachat®) was chosen as the data collection software for three reasons: 1) participants did not have to download any new software to participate in the focus groups (although I found out during data collection that Java® was required), 2) Parachat® provided me with chat room facilities to host the focus groups, and 3) transcripts of each focus group were made available for me to analyze immediately following each focus group (Parachat, 2011). Two days before each focus group, all participants were sent a reminder email (see Appendix H) with the date and time of the scheduled focus group along with individualized log-in information. The log-in information contained the participant's code name so no identifying information was visible to me or other participants during the focus groups. The reminder email was sent again to each participant the day of their focus group.

At the onset of each focus group and interview, I answered any questions participants had before beginning the questions. I emphasized that participation in the focus group or interview

implied informed consent. Focus groups and interviews lasted up to 50 minutes and were organized to keep the number of participants in each group small enough (6-9 people) to encourage participation from all and to enable in-depth discussion of all research questions (although most of the focus groups had less than 6 participants). Focus group and interview questions (from the interview guide) were based on the research questions and elicited recommendations about potential roles for health educators in health care reform and individual, health service, societal, and policy components that should be in place for an effective health care reform plan to succeed (from the *Healthy People 2020* determinants of health ecological model). I served as the facilitator during each focus group and interview. I tried to elicit feedback from all participants and refrained from providing any thoughts and opinions of my own, to keep from biasing the discussion. At the conclusion of each focus group and interview, I thanked participants for their time and input. The text from the online focus groups and interviews was saved as a Word file to enable thorough data analysis to begin immediately following each focus group. See Appendix J for a sample transcript.

Also, immediately following each focus group, I wrote in a reflective journal to record my thoughts and opinions. Entries in the reflective journal included my feelings about the success or problems in each focus group and interview; my subjectivities before, during, and after each focus group and interview; and potential modifications that needed to be made to the focus group questions or in subsequent online focus groups or interviews. The reflective journal served as data, along with the focus group and interview transcripts, to allow the reader to understand how I arrived at the results and conclusions of the study (Merriam, 2009, p. 219). Entries from the reflective journal were incorporated into the results chapter along with rich, thick descriptions from focus group participants.

In qualitative research, the idea is not to have a specific sample size in mind before beginning the study. The goal is to continue to collect data until saturation, or until no new information is being provided by the research participants (Lincoln & Guba, 1985). In this study, I continued to conduct online focus groups and interviews until beyond the point that data saturation was achieved. Data collection occurred during three weeks, and data saturation occurred after the first week (following the first three focus groups and two interviews). I chose to continue with data collection until all scheduled focus groups were complete in order to ensure no new ideas would emerge and to increase participation rate. Also, the data collection process was reflexive in nature, meaning that changes were made to the focus group discussion questions during the data collection process in order to enhance discussion and get in-depth answers from participants that answered the research questions.

Data Analysis

Data analysis is the process of making sense out of the data. And making sense out of the data involves consolidating, reducing, and interpreting what people have said and what the researcher has seen and read – it is the process of making meaning. Data analysis is a complex process that involves moving back and forth between concrete bits of data and abstract concepts, between inductive and deductive reasoning, between description and interpretation (Merriam, 2009, pp. 175-176).

After each focus group, each participant's responses were printed out and color-coded (using different colored paper) by workplace setting (e.g. blue for school setting, purple for community setting, etc.), letter-coded by experience group (e.g. A for less than 5, B for 6-15, etc.), and number-coded by gender (e.g. 1 for female, 2 for male). This process allowed for easier comparisons of recommendations later in the analysis process. The first step in data

analysis was simply to read the transcripts and make notes in the margins. This initial procedure allowed for development of tentative ideas about themes or relationships among themes (Maxwell, 2005). After the initial read-through, data from each focus group were sorted into categories according to the research questions. The categories were pre-determined ecological model categories (individual, health service, societal, and policy). Once data were coded and categorized, each category was analyzed and sorted to identify overarching themes and recommendation areas; and rich, thick descriptions from the online focus group transcripts were utilized to give meaning to each theme and area. A rich, thick description is not simply a quote, but it is an in-depth response about the phenomenon being studied that thoroughly explains a theme or research question. As data from each focus group and interview was analyzed, I looked for themes and recommendation areas that were the same or similar to those already identified. These themes and areas were recorded, and they were changed, narrowed, or combined with other themes and areas as data analysis continued (Merriam, 2009).

In addition, the data analysis was ongoing, beginning after the first focus group and continuing until all focus groups and interviews were complete and data was saturated. According to Merriam (2009), this is very important because:

Without ongoing data analysis, the data can be unfocused, repetitious, and overwhelming in the sheer volume of material that needs to be processed. Data that have been analyzed while being collected are both parsimonious and illuminating (Merriam, 2009, p. 171).

Member checking was used to solicit feedback about the emerging themes from focus group participants as well as to increase credibility of the study (Merriam, 2009). After each focus group transcript was coded, I emailed (see Appendix K) each person the focus group transcript with his or her coded responses in bold face and the coded meanings in the margins

and asked that they confirm my meaning of their responses. Participants were given one week to respond to the email if they had any changes or additions to make. No changes were made to my analysis during the member checking process. I conducted all data analyses, and no computer software was used to identify overarching themes or recommendation areas.

I kept a reflective journal to record in after each focus group and interview. Describing thoughts and feelings after each focus group allowed for identification of any biases and subjectivities, along with contributing to the reflexivity of the results (the audience is able to get a representation of my viewpoint throughout so they can make their own assumptions about the trustworthiness of the results). Information about the research process, concerns about the wording of interview questions, and notes on important discussions was all recorded in the reflective journal. Writing in the reflective journal allowed me to think through various approaches for methods of analysis, contemplate frameworks for thinking, determine who will benefit from this research, and think through concerns of how participants may have interpreted my portrayal of their statements (Ortlipp, 2008). The contents of the reflective journal was also be included in the results chapter of the study as this information allows the reader to better understand the decisions made during data collection and analysis as well as interpreting the results from my perspective. Table 5 outlines the timeline used for all data collection and analysis activities following human subjects approval.

Trustworthiness

Lincoln and Guba (2000) considered a study is trustworthy when results are authentic. Specifically, they urge researchers to question a study's trustworthiness by the following:

that I may trust myself in acting on their implications? More to the point, would I feel sufficiently secure about these findings to construct social policy or legislation based on them (Lincoln & Guba, 2000, p. 178)?

Table 5

Research activities timeline

Week	Research Activity	Associated Appendix
1	Participant recruitment Pilot	D
2	Participation recruitment Review pilot & make modifications	D
3	Selection of study participants	E
4	Organization of focus groups	G
5	Data collection (1 st set of focus groups) Reflective journal entry 1	F, H
6	Data analysis (1 st set of focus groups & reflective journal 1)	
7	Data collection (2 nd set of focus groups) Reflective journal entry 2 Member checking (1 st set of focus groups) Peer review	F, H I
8	Data analysis (2 nd set of focus groups & reflective journal 2) Organization of 3 rd set of focus groups	E, G
9	Data collection (3 rd set of focus groups) Reflective journal entry 3 Member checking (2 nd set of focus groups)	F, H I
10	Data analysis (3 rd set of focus groups & reflective journal 3)	
11	Member checking (3 rd set of focus groups) Peer review	I
12	Drawing for incentive	

This statement was exactly the aim of the study, so having trustworthiness was extremely important.

While many researchers are familiar with the terms internal and external validity and reliability in quantitative studies, Lincoln and Guba (1985) developed terms for their qualitative counterparts: credibility, transferability, dependability, and confirmability. Credibility is similar to internal validity in a quantitative study, and a qualitative study is credible when it represents the truth. Transferability is similar to external validity in a quantitative study. When a qualitative study is transferable, it can be generalizeable to different populations and at different times. Dependability is similar to reliability in a quantitative study. Ensuring a qualitative study's dependability means ensuring the consistency of study and its processes. Finally, confirmability of a qualitative study is similar to having objectivity, and ensuring confirmability means ensuring neutrality (Lincoln & Guba, 1985). In order to ensure credibility, transferability, dependability, and confirmability in qualitative research, Merriam (2009) proposes the use of some of the most common strategies for ensuring trustworthiness. See Table 6 for information on these common strategies.

The focus group transcripts, reflective journal entries, and peer review (scanning of the data by a colleague) to determine if the themes or findings are plausible or make sense in the context of the study (Merriam, 2009, p. 220) contributed to triangulation, or use of multiple sources of data and multiple investigators (peer review) to confirm findings (Denzin, 1978). Member checking was also be used to clarify meanings of participants' responses after the focus group sessions. This clarification supported my claim that the study results were not misinterpreted. Because the focus groups continued until data saturation, adequate engagement

in data collection was also a strategy used in this study. The reflective journal served as a tool to ensure that my position or reflexivity was accounted for in the study, as I documented my subjectivities that may have affect the results of the study. Peer review was also used because a health education colleague scanned focus group transcripts to determine if themes or findings were plausible. The detailed account of methods in this chapter serves as an audit trail so the reader can follow the process closely. Rich, thick descriptions of participant responses was used to interpret the results of the study, and maximum variation purposeful sampling was the method of sample selection to obtain a sample of health educators that represented a wide range of characteristics of interest.

Table 6

Strategies for Promoting Trustworthiness

Strategy	Description
Triangulation	Using multiple investigators, sources of data, or data collection methods to confirm emerging findings.
Member checks	Taking data and tentative interpretations back to the people from whom they were derived and asking if they are plausible.
Adequate data collection	Adequate time spent collecting data such that the data become “saturated.”
Researcher’s position	Critical self-reflection by the researcher regarding assumptions, worldview, biases, theoretical orientation, and relationship to the study that may affect the investigation.
Peer review	Discussions with colleagues regarding the process of study, the congruency of emerging findings with the raw data, and tentative interpretations.
Audit trail	A detailed account of the methods, procedures, and decision points in carrying out the study.

Table 6

Strategies for Promoting Trustworthiness cont.

Rich, thick descriptions	Providing enough description to contextualize the study such that readers will be able to determine the extent to which their situations match the research context, and, hence, whether findings can be transferred
Maximum variation	Purposefully seeking variation or diversity in sample selection to allow for a greater range of application of research findings by consumers of the research.

Note. Table reprinted from Merriam (2009, p. 229)

Summary

Chapter 3 explained the methods for this study. A qualitative, interpretivist approach was the basis for this study's design, where online focus groups were the primary means of collecting data. Maximum variation purposeful sampling was the method for obtaining the study's sample in which a list of CHES and MCHES certified health educators was purchased from NCHEC and committed health educators of various workplace settings, years of experience in the profession, and gender were chosen to represent health educators of different characteristics of interest. Data collection procedures (semi-structured, online focus groups and interviews, and reflective journal) along with data analysis methods (coding and categorizing) were also explained in detail in the chapter. Furthermore, a detailed explanation of trustworthiness of qualitative studies was described along with strategies utilized for increasing trustworthiness in this research (triangulation, member checks, adequate data collection, researcher's position, peer review, audit trail, rich, thick descriptions, and maximum variation). Chapter 4 describes the results of this study.

CHAPTER FOUR

RESULTS

Purpose of the Study

The primary purpose of this study was to explore recommendations from health educators for health care reform in relation to the different levels of the determinants of health ecological model. Additionally, this study examined the potential new roles participants identified as important for the health education profession in achieving an effective health care system.

Research Questions

- 1) From a health education perspective, what individual, health service, societal, and policy components should be in place for a successful health care reform plan to succeed?
- 2) What roles in health care reform do participants see as potential roles for health education professionals?
- 3) How do health educators advocate or act on policy issues related to access to health care/ health care reform?

Participants

A large number of health education specialists (60 community health educators indicated interest in participating, followed by 55 post-secondary, 34 medical, 23 worksite, 17 organization/ foundation, and 11 school) agreed to participate in the study (n=200). However, the final sample size quickly declined as participants were unable to fit the available focus group times into their schedule or had something come up the day of their scheduled focus group that prevented them from attending. I tried to conduct at least two focus groups for each workplace setting. Sixteen focus groups were scheduled, but two were cancelled due to lack of attendance, two were converted into interviews as only one participant attended, and four of the focus groups

held contained health educators in various workplace settings in an attempt to increase participation rate.

The final study sample included 50 participants (0.57% of total population) representing all six selected workplace settings, both genders, and various years of experience in the field of health education. The majority of participants (n=20, 40.00%) identified their workplace setting as post-secondary, followed by community (n=14, 28.00%), medical (n=6, 12.00%), organization/ foundation (n=4, 8.00%), worksite (n=4, 8.00%), and school (n=2, 4.00%). Nearly half (n=21, 42.00%) of the participants indicated working in the field of health education for 6-15 years, followed by 24% (n=12) of participants working in the health education field for 16-25 years, 12% (n=6) working in the health education field for 26-35 years, 12% (n=6) working in the health education field for more than 35 years, and only 10% (n=5) working in the health education field for five or fewer years. Seventy-two percent (n=36) of the sample were female with 28% (n=14) being male. Although participation rate was lower than expected, data saturation was reached well before the 12 focus groups and two interviews were over. Data collection occurred during three weeks, and data saturation occurred after the first week (following the first three focus groups and two interviews). I chose to continue with data collection until all scheduled focus groups were complete in order to ensure no new ideas would emerge and to increase participation rate. See Table 7 for a summary of demographic information arranged by workplace setting (also see Appendix L for a more detailed description of participant demographics and Appendix M for a description of participants in each focus group or interview).

Table 7

Participant Demographics/ Characteristics of Interest

Workplace Setting	Total (n)	Male (n)	Female (n)	Years of Experience (\bar{x})
Community	14	3	11	17.71
Medical	6	2	4	16.17
Organization/Foundation	4	1	3	20.75
Post-Secondary	20	7	13	16.70
School	2	0	2	16.00
Worksite	4	1	3	15.50

Results

As data analysis occurred, a few important findings emerged that are important to take into consideration when reviewing results. First of all, there were no differences in recommendations made based on gender and years of experience. Conversely, there were slight differences in recommendations made based on workplace setting, and those differences will be noted throughout the chapter. Also, the information that I will describe in this chapter represents recommendations made by participants in all, or nearly all, of the focus groups. Therefore, they are not recommendations made just once or twice. However, Figures 1-6 do detail all recommendations made, regardless of the number of times they were mentioned by participants. Finally, grammar and spelling mistakes of participants' quotations were corrected before their inclusion in the results.

Advocacy Experiences

Information about the types of advocacy experiences participants have had was obtained during the focus groups. While this information does not directly relate to the main purpose of the study, I thought eliciting types of advocacy experiences from participants would provide additional meaning and credibility of participants' recommendations for the health care system by illustrating to the audience that they do have a wide variety of experiences advocating for health or health education. Also, asking participants about their experiences advocating for health or health education served as an effective "ice breaker" as it was the interview question asked first.

Participants did prove to have advocacy experience at local, state, and national levels; many at multiple levels. The level most commonly reported for advocacy efforts was the state level, followed by the national level and the local level. Many participants also advocated as members of professional associations/ organizations, and community and post-secondary health educators tended to be the ones most likely to advocate in this setting. Along with advocating as part of professional associations/ organizations, some participants performed advocacy activities as a member of a coalition, and others performed advocacy activities as part of their employment. Participants from all workplace settings reported advocating while attending professional meetings (conferences, workshops, summits, etc.). Post-secondary health educators frequently reported writing policy memos, writing letters to Congressmen, analyzing policies, and taking students to congressional sessions where health laws were being discussed. Other participants reported advocating on more informal occasions where they tried to empower family and friends take control of their health or take action regarding health care reform issues. Finally, two participants reported advocating via health care reform proposals. One post-

secondary health educator reported she was a speaker for President Clinton's health care reform proposal, and another post-secondary health educator reported advocating for the *Section 1115 Waiver*, which is a component of the current health care reform proposal.

The Reform Plan

After providing types of experiences advocating for health or health education, participants were asked to describe the components they would include in an effective health care reform plan if they were on a committee in charge of making such a reform policy. This information was elicited to serve as the foundation from which to make recommendations at each level of the *Healthy People 2020* determinants of health ecological model. The three major areas of recommendations that emerged from the data were prevention, access, and streamlining. While participants explored a variety of ideas regarding how to obtain prevention, access, and streamlining, these three areas were expressed as important in every focus group and interview. In fact, many participants believed that multiple, or all three, areas were essential to an effective health care reform plan. Two participants, one belonging to the organization/foundation setting and one belonging to the post-secondary setting, expressed this belief during focus group sessions. The organization/foundation health educator stated:

I think we can all agree that healthcare reform is necessary in this country. I agree that healthcare coverage is a right that all citizens should have. The problem is paying for such a program. Having worked in *Medicare* and *Medicaid*, I understand the shortfalls in our current system, and I feel that it is best to develop a completely new program that can be administered by the private sector in a cost effective and efficient manner. The program will have to be effectively managed to control costs in order to provide everyone with basic benefits. I think the basis must be that each individual select a primary care

physician (PCP) to coordinate their care and manage referrals to specialists. The patient must consult their PCP except in emergency situations. We need to develop regional networks of contracted providers to provide care at discounted rates. All hospital admissions and critical care should be coordinated through a multi-disciplinary team based on an appropriate plan.

The post-secondary health educator recommended primary prevention should be the focus for all health care activities and the mindset of the American public. In addition, she believed funds should be available for health education and health promotion programs to promote primary prevention efforts and education. Furthermore, this participant expressed the need for a universal health care system where everyone is covered and prevention is the focus. Finally, the participant recommended a larger government role in the pharmaceutical industry, particularly for the “government to purchase contracts with drug companies” to control medication costs, as well as the adoption and use of computer smart cards for Americans in an attempt to reduce administrative costs because the computer smart cards could be “swiped” at every health care facility a person goes to in order to keep track of all health records, insurance plans, billing information, etc. Other participants did not mention all three areas of recommendations like these two participants did, but the ideas expressed by these participants were commonly mentioned throughout the majority of the focus groups and represent the overall consensus of the participants.

Prevention. The most frequently recommended single area/ component of the reform plan was prevention, with specific mention of prevention aspects such as insurance coverage for preventive services, the need for increased health literacy, and prevention education for primary care physicians. Many participants spoke of the need for “prevention services, such as

screenings, as well as providing clients with appropriate education to lead a healthier life.” For instance, a community health educator stated, “I think healthcare should weigh heavily on prevention. It’s unfortunate that preventative care has not been covered. It would solve the issue of people getting so sick and the costs associated with their illnesses.” In response to this statement, another community health educator added, “I agree. We really need to include prevention and health care screenings. For instance, in order for me to have my cholesterol checked I had to have a history of heart disease. That should not be the case.”

Other health educators related prevention to financial burden, but emphasized the importance of making responsible end-of-life decisions as they, too, contribute to “a HUGE portion of our health care costs.” For example, when a person is diagnosed with a fatal disease (or even before), it may decrease health care costs if the person would communicate his/her end-of-life preferences, such as “do not resuscitate,” in an attempt to state their wishes clearly and prevent any unwanted treatments that may prolong the quantity of years/ hours of life, but not the quality of life. In addition, participants believed that health professionals need to be trained to deliver prevention education as “there is a general low self-efficacy level for many health care providers” with regard to providing prevention education.

A health educator working in the medical setting linked the need for increased health literacy to an increase in obtaining prevention services. She also thought that one way to obtain such goals was to have a health care provider “integrated in the community that didn't have an ‘untouchable’ persona” as this person could help to increase health literacy and reinforce the importance of prevention. Based on her experiences in the medical setting, she believed people needed to develop a rapport with their health care provider before they will trust their diagnoses and adhere to their medical/ prevention recommendations.

Health educators in all workplace settings spoke about the importance of specific prevention activities for the family. A post-secondary health educator captured the essence of this idea as she stated:

I would love to see positive health decisions supported by the reform such as gym memberships, counseling, nutrition consultation, and more programs like that before an issue has arisen; really promoting FAMILY health, not just child health.

Participants in various settings also described incorporating health education, and health educators, into public prevention. One common perspective on the issue involved “the option for individuals to work with a health educator, or nurse educator, to develop individualized prevention health plans.” In doing this, participants saw an opportunity for health educators to work with individuals to address their health condition, physical and nutritional needs, food access, cultural influences and physical environment in order to develop a personalized plan for them that will promote prevention activities and enhance their health and quality of life. Many participants encouraged activities such as this because they believed “the current health care system doesn't value the cost benefit of preventive health care in reducing the cost related to treatment and management of diseases, e.g., obesity.”

In addition to increasing the use of health educators, there are teachable moments when people seek health care and prevention services, but “often, health care providers do not take the time to educate people.” This idea emphasizes the importance of prevention and illustrates the need for health educators because we are professionals who do take the time to educate people about prevention via prevention and health promotion programs. A participant responded to the idea by stating, “It would be great if people were given ‘prescriptions to see health educators who could spend time on topics of disease health care and disease prevention with people.”

While prevention was the most frequently recommended component of an effective health care reform plan, participants also acknowledged the difficulties in trying to obtain acceptance for prevention, mainly because prevention tends to be thought of as a subjective term. “It’s difficult for people to measure ‘prevention.’ They are accustomed to the problem/cure mentality and have more trouble comprehending how to prevent problems or minimize health risks.”

Access. Access was another area/component discussed as essential for an effective health care reform plan. Access to health care in general was mentioned the most, although participants had different preferred methods for obtaining (or requiring) access to health care. Participants from every workplace setting believed that universal health care was an essential component of a reform plan, and “should be made available to everyone regardless of SES (Socio-Economic Status).” In essence they believed “there has to be an option to assure that every single person is able to get a basic level of care,” whether it be mandated, optional, or included in a variety of choices. A commonly reported reasoning for the need for universal health care was, “We cannot expect health care costs to go "down" when people are not accountable for their actions, not acting responsibly for their health and illness.”

Participants also had ideas regarding access to specific types of health care services and activities. Many believed people should have an increased access to alternative therapies and methods for treatment focusing on holistic health rather than medication. Others noted that people need access to healthy environments to promote health, including:

...things like walk-able/ bike-able neighborhoods, access to healthy foods and tobacco-free environments. They need to be built into the system and the cost structure so that

public health actually gets paid to do the prevention work that counts most toward good outcomes.

Streamlining. Another area/ component thought to be an important part of a health care reform plan was streamlining, specifically with regard to health care administration and overall costs of the health care system. There was a small amount of disagreement among participants regarding whether there should only be a single insurer or whether there should just be fewer insurers. While all participants who mentioned insurer role as important said the number of insurers should be smaller as the large number contributes to our complex system with high administrative costs, some participants simply stated that the number of insurers should be decreased while others stated that there should only be one insurer. One reason for the need to decrease the number of insurers, as expressed by participants, was because “a major cost comes from the back and forth negotiations between health insurance companies and doctors’ offices.”

Still other participants spoke about the physician’s role in decreasing cost and streamlining the health care system. A participant in the organization/foundation workplace setting wanted to prevent physicians from having individual private practices as she believed the presence of private practices was “a huge waste of resources and overhead; administrative costs.” She also believed “all licensed medical providers should be required to provide a small percentage of charity care in order to keep their licenses.” Her idea requiring medical providers to provide charity work was a recommendation shared by many other participants. However, only a few participants agreed with the need to prohibit physicians from having individual private practices.

A final streamlining recommendation was to contain health care costs. Participants firmly believed that payment reform is an essential component of any health care reform

proposal. In addition, they believed that offering incentives to both patients and health care providers would aid in health care cost reduction. If the health care provider were given incentives (such as increased reimbursement rates) to provide prevention services/ education he/ she will be more likely to offer the prevention service/ education. In addition, the patient also will be more likely to engage in prevention activities if he/ she is given an incentive (such as decreased co-payment amounts) to do so. The following is an interesting discussion (reflective of similar discussions in other focus groups) among three participants in the community setting about this issue:

It [health care reform plan] would need to restructure incentives for providers and patients to engage in evidence based prevention, early detection and chronic disease management/self-management activities. Without payment reform we're sunk.

The Incentives will be tricky, however, I do believe cost containment measures should include individuals who persist in behaviors, which have been deemed as unhealthy, burdening more of the share of health care costs than others, who are practicing healthy behaviors.

No, cost sharing would never fly and would polarize groups who advocate for obesity and addiction as a disease.

There seemed to be no differences in recommendations made for the reform plan by gender, years of experience in health education, or workplace setting, with the exception of one health educator working in the medical setting who wanted to address informed consent issues within a health care reform proposal.

Overarching Themes

The remainder of this chapter describes recommendations made at each level of the *Healthy People 2020* determinants of health ecological model as well as potential roles for health educators in light of those recommendations, and priority recommendations (priority recommendations were elicited from participants at the end of each focus group and were meant to encompass those recommendations that needed to be addressed quickly). During my analysis of these recommendations, I noticed three overarching themes that seemed to serve as a thread linking all levels and areas of recommendations. The three themes are prevention, health literacy, and a focus on the larger levels of the *Healthy People 2020* determinants of health ecological model. These overarching themes are portrayed before describing the recommendations, so the readers can more easily observe/ notice themes while reading through the recommendations.

Prevention. Just as prevention was a recommended area/ component of the reform plan, it was described in some way at each level of the *Healthy People 2020* determinants of health ecological model. For example, participants recommended that individuals need to be provided with knowledge about prevention services available, empowerment to take control of their health care and seek prevention services, and skills to set prevention-oriented goals. In addition, participants believed health services necessary for a health care reform plan to succeed should include an increase in prevention-oriented services. They believed that those health care practitioners engaging in prevention activities should be covered by health insurance. Well-care checkups and screenings should be increased to promote prevention, and they believed that prevention programs should be more readily available. At the societal level, participants wanted to live in a society where prevention was the social norm, rather than treatment. They also

wanted to increase healthy environments that promote prevention activities such as physical activity and healthy eating patterns. At the policy level, participants expressed the need to educate policy makers on the importance of prevention in health care reform proposals. They also proposed a campaign to market those proposals containing prevention initiatives and prevention funding. Participants also saw health educators providing prevention education to the public, to health care providers, and to policy makers to promote a prevention-oriented society and health care system. Finally, the most frequently mentioned priority recommendation was to adopt a universal health care system with an emphasis on prevention.

Research question one states, “From a health education perspective, what individual, health service, societal, and policy components should be in place for a health care reform plan to succeed?” So, what is a health education perspective? After exploring recommendations from health education specialists at these various levels, I have come to believe that a health education perspective is that of a prevention-oriented mindset. These participants clearly saw prevention as an important aspect any successful and effective health care reform proposal, and they spoke of prevention more than they spoke of any other single idea.

Health Literacy. Health literacy was also a recommended area/component of the reform plan that emerged throughout data and was described in some way at each level of the *Healthy People 2020* determinants of health ecological model. Health literacy is defined as “the capacity of individuals to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways that enhance health” (Joint Committee on Health Education Standards, 1995, p. 5). For instance, the individual level recommendation areas were knowledge, attitudes, and skills, but the definition of health literacy encompasses the need for knowledge, attitudes, and skills necessary for using information and

services in health enhancing ways. Also, participants recommended creation of a personal health navigator to help Americans increase their health literacy regarding health services available and to guide them to appropriate services. They saw health educators as essential in the creation of the personal health navigator. In addition, participants thought health education efforts should be increased at the societal level in an attempt to increase the health literacy levels of Americans. Finally, they wanted to incorporate health literacy initiatives in health care reform proposals.

Health literacy is a primary goal of school health education (Joint Committee on National Health Education Standards, 1995), but Nutbeam (2000) describes health literacy as a public health goal as well. He states that health literacy, particularly high levels of health literacy, lead one to critically analyze information and use the information to have a greater control over one's life events, which includes his/ her ability to navigate the health care system or make health enhancing decisions regarding health care (Nutbeam, 2000). With 90 million people in the United States having difficulty understanding and using health information (Institute of Medicine, 2004), thus having low health literacy levels, it is not surprising that participants would want to increase health literacy among the U.S. population via health care reform proposals.

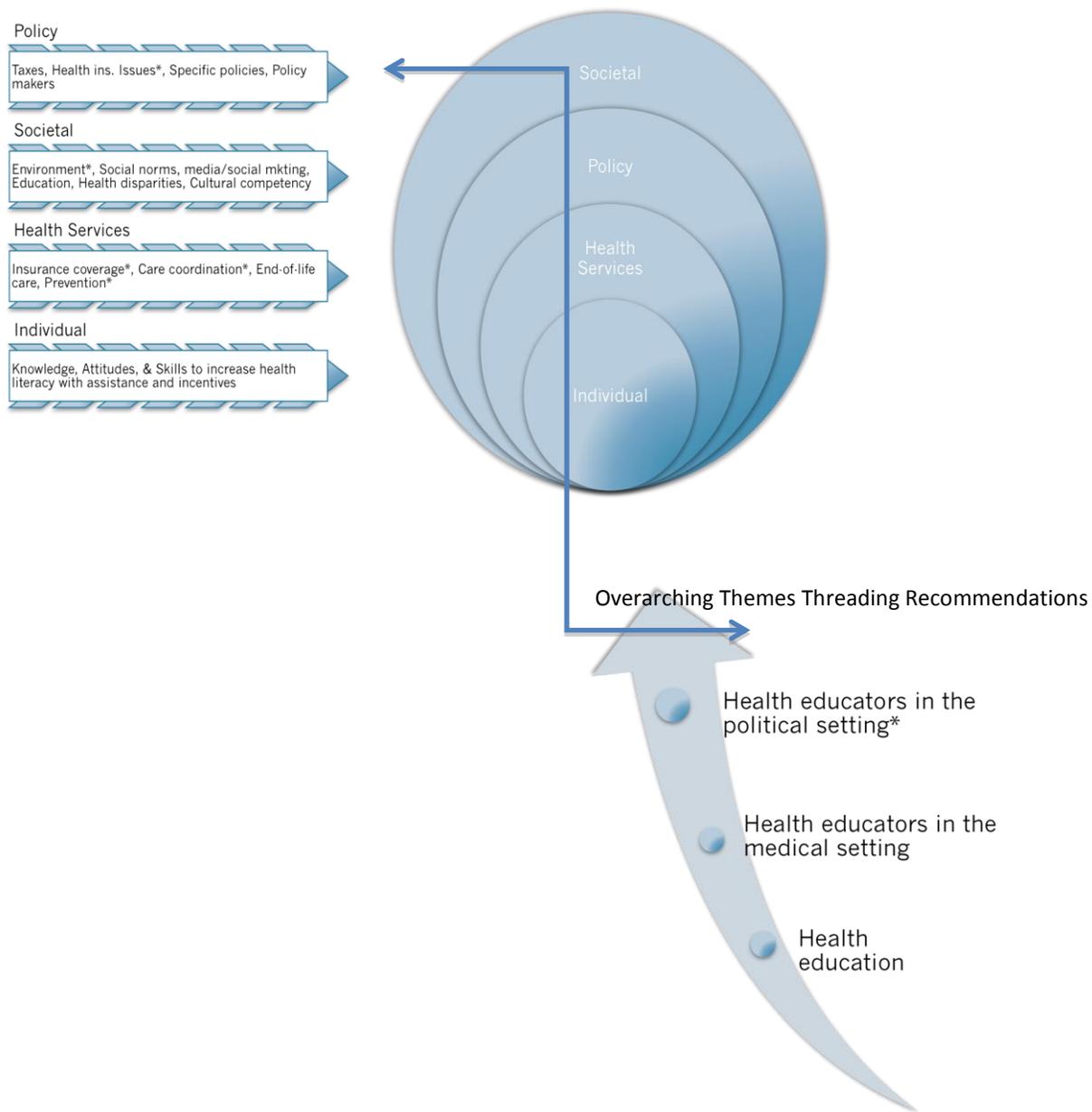
Focus on Higher Levels. The recommendations elicited in this study utilized four levels of the *Healthy People 2020* determinants of health ecological model: individual, health services, societal, and policy making. Interestingly, when I asked participants what individuals needed in order for their health care reform proposal to be successful, many participants noted the importance of focusing at higher levels of the *Healthy People 2020* determinants of health ecological model, rather than focusing so much at the individual level. Therefore, this larger level focus was another theme that seemed to be present throughout the majority of

recommendations. Many participants stated efforts to increase the health of the population should be efforts to change the environment and pass policies to encourage healthy behaviors. They also offered the majority of their priority recommendations within the larger levels of the *Healthy People 2020* determinants of health ecological model. Furthermore, there were no priority recommendations within the individual level.

Research results have shown that health educators typically focus on the individual level when attempting to influence behavior change (Holtrop, Price, & Boardley, 2000 & Freudenberg, 2006), but these attempts are often ineffective (Schneider & Stokols, 2009). After analyzing the data of this study, I have come to believe that there may be a shift occurring in the health education profession regarding individual level efforts versus multi-level or population/ environmental/ policy efforts. Health educators today may be more willing to focus on multiple levels when attempting to influence behavior change. The participants in this study at least see the benefits of targeting their efforts at these larger levels. Figure 1 depicts the recommendations made at each level of the *Healthy People 2020* determinants of health ecological model (excluding the biology and genetics level). It also illustrates the recommended roles for health educators, priority recommendations, and the link of overarching themes.

Figure 1

Areas of Recommendation



Note. * represents a priority recommendation

Health Educator Role

Recommendations at Each Determinant of Health Level

The theoretical framework used in this study was that of the *Healthy People 2020* determinants of health ecological model (USDHHS, 2011). The model is comprised of five determinants of health, each of which interacts together and influences the health status of individuals, communities, and society. The five determinants are biology and genetics, individual behavior, health services, social factors, and policy making (USDHHS, 2011).

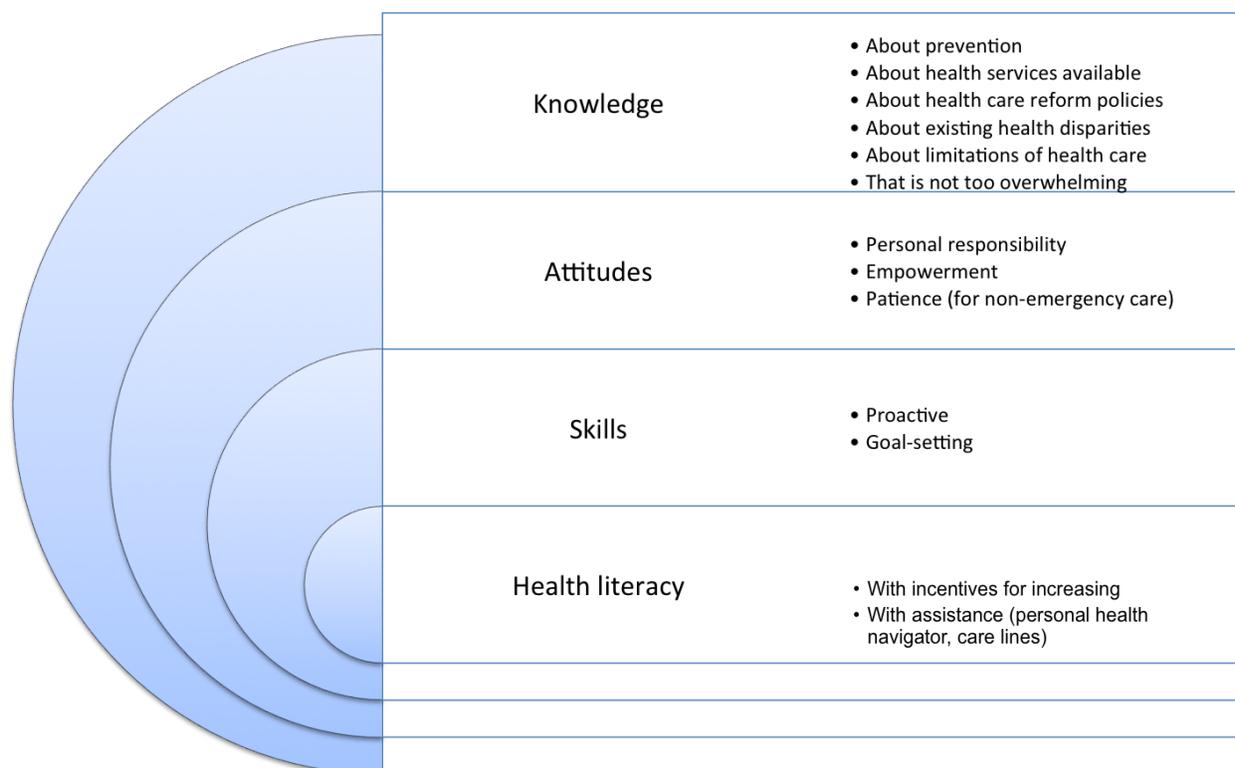
As previously stated, health educators typically develop interventions or programs that target primarily individual level behaviors (Holtrop, Price, & Boardley, 2000 & Freudenberg, 2006). However, the large number of individual level behavioral interventions that have failed to improve the health status of participants illustrates the need to think of health education on a broader scale (Schneider & Stokols, 2009). According to the USDHHS (*Healthy People 2020*; 2011), interrelationships among these determinants influence the health of individuals and communities, and targeting multiple determinants of health increases effectiveness – including health care reform. Interview questions were intended to bring forth ways in which the *PPACA* (Public Law 111-148; or other health care reform proposals) could target multiple determinants of health to improve the health care system/ access to health care and the health of American people.

Individual. Despite the fact that research results have shown many interventions focusing on only individual level behaviors have proven to be ineffective (Schneider & Stokols, 2009), individual level behavior changes can affect health outcomes. For example, if one starts exercising and eating healthy, one's chances of developing type II diabetes and high blood pressure decrease. Other examples of individual behavior changes that affect health are consuming alcohol, tobacco, or other drugs, wearing a seatbelt, getting vaccinated, etc.

Participants offered many recommendations relating to what individuals would need for a health care reform plan to be successful. The four areas of recommendations that emerged from focus group and interview data include knowledge, attitudes, skills, and health literacy (which encompasses ideas relating to the previous three areas). See figure 2 for a description of all recommendations mentioned within the individual level.

Figure 2

Individual Level Recommendations



Just as participants had differing ideas of how best to achieve the recommended components of the reform plan, they also had varying ideas about how best to foster knowledge, attitudes, skills, and health literacy in individuals. Individual level recommendations did vary somewhat by workplace setting. For instance, worksite health educators were most likely to recommend the need for knowledge of health services available. Also, a post-secondary participant described a project she assigned to her students to illustrate the need for people to have knowledge about health care reform policies. Post-secondary health educators also were more likely than health educators in other work place settings to recommend that individuals have skills to act in health enhancing ways.

Knowledge. Regarding knowledge, participants (especially those in the worksite setting) believed individuals needed to have knowledge of the health services available to them as well as knowledge about needed prevention activities. One worksite participant described the need for knowledge as she explained the need to be knowledgeable about screenings and when to get them. She said it is very important for citizens to know when to get an annual physical, when to get a mammogram, and when to get a colonoscopy. She also spoke about the need to know when it is appropriate to use different health service centers such as the Emergency Department, versus the Urgent Care Center, versus a regular physician's office. The majority of participants also spoke of the need for this because Emergency Department use contributes a large portion of the health care costs Americans must pay for.

Other participants believed that individuals also must have knowledge about health care reform policies and health insurance options. A participant working in the post-secondary setting provided an example of how she educated her class by having them visit the website (www.healthcare.gov) and review the *PPACA*. She wanted to counteract the fact that "people

dismiss it without realizing that things in the law are good for THEM.” Participants thought an increased knowledge of health care reform policies would decrease the vast amount of misperceptions present in society today, and they believed that the knowledge would also provide participants with a core content to make better decisions about their health care.

Finally, participants realized individuals and families not only need to be educated about the benefits of health services available to them, but they also need to be educated about the limitations of certain health services/ activities. They believed this type of knowledge would also allow for better health care decision making that would improve health and decrease health care costs for everyone. For example, “ventilators provide an extension of life but will not necessarily cure diseases like cancer, etc. In other words, we can prolong life, but what about the quality of life? It is hard to get families to realize that the only reason their loved one is alive is because of a ventilator, etc.”

Attitude. Addressing attitudes was an area for which participants had recommendations. The main recommendations addressing attitude were the need for personal responsibility and empowerment of individuals. Participants from all workplace settings believed that individuals must be empowered in order to take a personal responsibility for their health. The general consensus was that “Americans (in general) don’t know how to care for themselves.... Many people rely on doctors and nurses, and that has to change.” A participant in the organization/foundation setting provided an example:

I had to “learn” that I should read nutrition labels to carefully select food. I had to “learn” why it was important not to smoke. I had to “learn” what a trans-fat was, what cholesterol was, and what carbohydrates were, but I also wanted to learn these things.

One reason participants believed personal responsibility to be important was because the health care choices made by people drive up the health care costs for all Americans. Participants wanted to see people become more personally responsible for their health so they can become accountable for their actions as they affect everyone.

Skills. Participants also made recommendations in the area of skills regarding their health and health care, particularly skills to become more proactive in obtaining preventive services and health care, and the ability to set goals pertaining to health. They believed these skills to be important because making healthy choices and health care decisions are not easy. “The basic suggestions for prevention sound simple to many of us, but I think they are bewildering.” Because health suggestions seem difficult to many, participants said people must develop multiple skills to enable them to analyze media messages to discern the most relevant and correct information, to notice environmental cues that may subconsciously promote unhealthy messages and become resistant to them, and to weigh the positive and negative effects (both short-term and long-term) of certain behaviors like smoking and drinking. “Instead of focusing so much on ‘do this and that,’ we need to simplify the healthy steps and encourage people to watch for pressures around them to do unhealthy things.”

Health Literacy. The most frequently mentioned recommendation at the individual level was for individuals to have an increased health literacy, which encompasses knowledge, attitudes, and skills. Mainly, participants believed individual Americans should have skills to read and comprehend prescription labels in order to take their medications correctly, and they believed that Americans also must have computer skills because a vast majority of health information, health services, and medical records can be located via computers/ mobile devices.

Many participants said computer and health literacy skills are essential for patients “so that when they can access their online records, they can access and understand.”

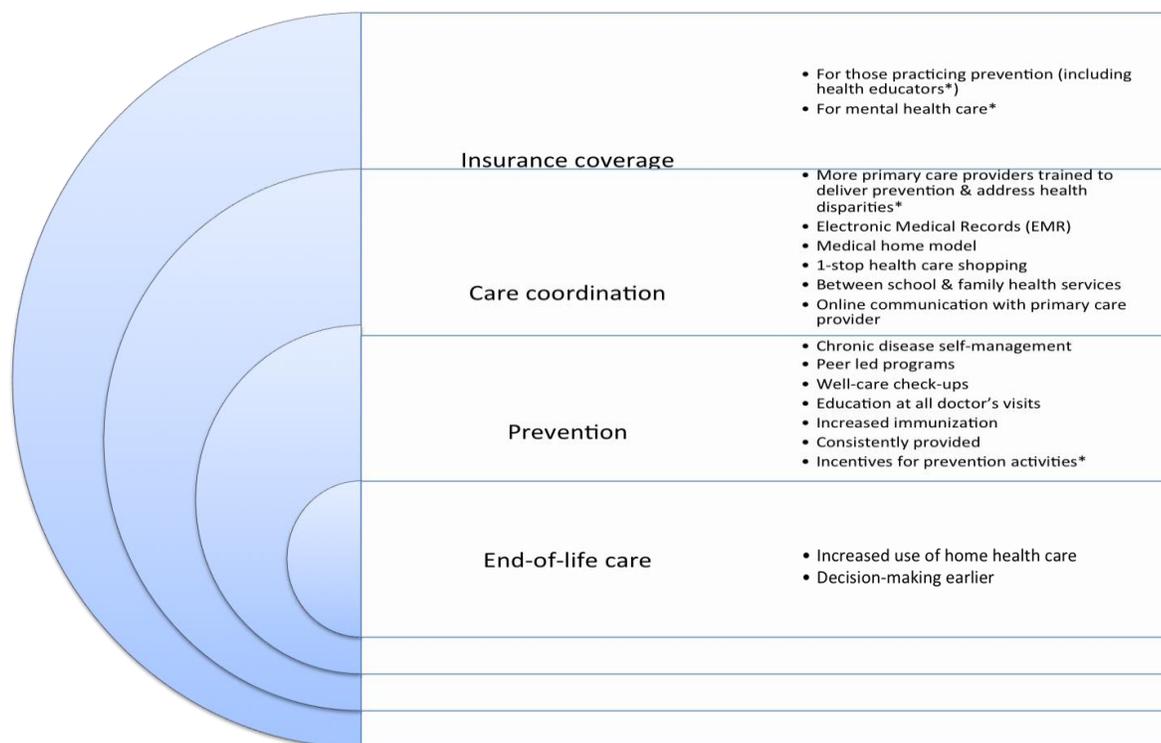
Participants believed that fostering health literacy was important, “especially now that so many people use the Internet to get information.” In addition, they thought teaching health literacy skills should begin at an early age. In order to increase health literacy, many participants thought individuals should be provided with some sort of assistance. One method proposed to assist people in developing health literacy skills was a “personal, easy-to-access, health navigator that can help you use the system most effectively.” Another method of assistance proposed was “care-lines for non-emergency issues where people can call to get advice (acute, chronic and prevention). That may cut down on unnecessary Emergency Room visits and increase prevention behavior.”

A final idea regarding recommendations made at the individual level that is important to mention was the notion that we should not focus on changes at an individual level, as we should be focusing on larger levels such as population and environmental changes. This larger level focus was describe as important because, “we are heading to the ‘blame the individual’ frame. I think we have an disease-causing environment and population level measures must be taken.”

Health Services. Health services is another level of the *Healthy People 2020* determinants of health ecological model because both access to and quality of health services can impact health. Potential barriers to accessing needed health services are lack of availability, high cost of insurance premiums or out-of-pocket expenses, or lack of insurance coverage. Presence of barriers to health services can eventually lead to unmet health care needs, delays in treatment or care, not being able to receive needed or recommended preventive services, and even hospitalizations (USDHHS, 2011).

At the health services level of the *Healthy People 2020* determinants of health ecological model, participants suggested a variety of recommendations that fell within four areas including offering insurance coverage for certain types of preventive care, having better care coordination, addressing end-of-life care issues, and focusing on prevention. Just as prevention was a major theme when participants spoke about the components of their own proposed health care reform plan and spoke about individual needs, prevention was also a major theme within the health services level of the *Healthy People 2020* determinants of health ecological model. In addition, there seemed to be no differences in recommendations made by different workplace settings at the health services level. Health educators in every workplace setting described all themes. See figure 3 for a description of all recommendations mentioned within the individual level.

Figure 3

Health Services Recommendations

Note. * represents a priority theme or subtheme.

Insurance Coverage for Prevention. Participants in every workplace setting agreed that many types of prevention oriented services/ professionals should be covered by health insurance. To be more specific, participants recommended that health care reform proposals include health insurance coverage for a broad array of practitioners such as mental health professionals, chiropractors, yoga instructors, personal trainers, and health educators. They believed that insurance coverage for these groups of people would increase their use, thus increasing the health of society. Mental health care coverage was the recommendation that most frequently occurred within the focus groups (along with coverage for health educators). Many spoke of the fact that mental health services “are minimally covered by insurance, even for high-earning families.” Participants believed that mental health is a dimension of health that is often dismissed in health care reform proposals. Because families in today’s society are facing many stressors, participants believed that mental health care is becoming increasingly important. Participants not only wanted to increase access to and provide insurance coverage for mental health care, but also they thought it was important to work towards decreasing the negative social stigma associated with mental health care. They expressed that people don’t feel comfortable saying they plan to see a psychologist (or other mental health care professional) because they fear the negative stigma attached to the idea.

Care Coordination. Care coordination was another area of recommendations expressed as important. Many participants spoke of the idea of adopting a medical home model that emphasized coordination and comprehensiveness of care. They spoke of the medical home model as having a team of health care professionals that communicate and coordinate the care of patients in order to effectively promote health and prevention. Participants also spoke about a similar type of care coordination between hospitals, doctors, care coordinators, outpatient

services, etc., in order to prevent people from relapsing and being readmitted to hospitals after they have been released. Participants said that oftentimes patients are released too early or don't receive the proper education on how to care for themselves, and therefore, have a relapse and have to be readmitted into the hospital. It was said that it's important to "assure that people don't relapse by coordinating care... this kind of coordination of care is critical."

In addition to coordinating care among different groups of health professionals, participants also recommended electronic coordination of care via electronic medical records. Participants recognized that "sadly, healthcare is such a late adopter of technology." They believed that electronic medical records are very important and that the electronic medical records systems that are in place are very effective. A participant in the medical setting provided an example, stating "I am in New York City and Columbia University Medical Center has a centralized medical record system that all providers can access, and then on the patient side, they have a site where patients' tests are uploaded so a patient can log in and see parts of their chart."

End-of-Life Issues. Addressing end-of-life issues was another health services recommendation area. Many participants from a variety of workplace settings believed that the U.S. spends exorbitant amounts of money on individuals in their last stages of life, and they believed that this was an issue important to address. A common perspective on this issue was, "we need to keep people comfortable in their last illnesses but not do heroic, high cost things, which may only prolong life for a few months (use the money earlier toward the beginning of life)."

Participants recommended communicating about end-of-life requests in order to prevent the exorbitant amounts of spending that occurs during the last stages of life. They addressed the fact that many people request certain medical treatments because open communication has not

occurred, but participants thought that if people were educated about how to communicate these wishes and the consequences of end-of-life choices, a great deal of suffering, and money, could be saved.

Prevention Focus. A final area of recommendations in the health services level was the importance of focusing on prevention and prevention programs. A health educator working in the medical setting spoke of many recommendations that other participants also proposed:

I think we could start with a public health model where we emphasize starting people with good health from the beginning and then continue the effort through the life span. This would mean comprehensive prenatal healthcare for all mothers, making sure that all children have enough to eat in their formative years, and providing vaccinations to prevent preventable diseases are also important. We need health education throughout the life cycle to help people make good health choices to minimize things like smoking tobacco and becoming overweight from poor food choices. It's also important to help people stay physically fit throughout the life cycle, teach stress management, and minimize environmental pollutants.

Another idea suggested was the use of chronic disease self-management programs where peers "help people take control and learn to effectively engage with the health care system," and educate those with chronic diseases to engage in healthy behaviors. Other suggestions for using peers as educators include "using pre-existing networks like school PTA's (Parent-Teacher Associations), community organizations, and religious communities to train peer health educators as it would be really beneficial and potentially low cost."

In addition, participants also recommended using well-care checkups as an effective means for prevention. They said a portion of each annual doctor's visit should include

prevention education, blood screenings, and discussion of any risky behaviors like smoking, unhealthy eating, etc. Furthermore, participants recommended a referral system should be in place during well-care checkups so a patient can be referred to a specialist if a serious illness is detected. However, while most participants liked the idea of having prevention education at well-care checkups, they noted that prevention education may sometimes “just be a nurse handing the patient a brochure at the end of the visit, which doesn't really help anyone.” Because of this, participants thought health care professionals “need remediation as to how to advise, when to advise, and what to do as far as prevention education resources. Health education could play a huge role there.”

A final prevention recommendation was to hold prevention training for health professionals so they are better equipped to provide prevention education with a focus on wellness. One suggestion was for “the medical school curriculum to include some sociology courses. The medical school curriculum is so heavily focused on the body (which is great!), but there is a heavy deficit in providers caring for the whole person. The body affects the mind and vice versa. Treating one without treating the other will always leave the patient not fully well.”

Finally, as I reflected on the many health services recommendations made and read through the focus group and interview transcripts, I noticed that many recommendations within the health services level were consistent with *Healthy People 2020* goals relating to access to health services (USDHHS, 2010). The goals addressed were as follows:

- Increase the proportion of persons with health insurance.
- Increase the proportion of insured persons with coverage for clinical preventive services.
- Increase the proportion of persons with a usual primary care provider.
- Increase the number of practicing primary care providers.

- Increase the proportion of persons who have a specific source of ongoing care.
- Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines.
- Increase the proportion of persons who receive appropriate evidence-based clinical preventive services.
- Increase the proportion of persons who have access to rapidly responding pre hospital emergency medical services.
- Reduce the proportion of hospital emergency room visits in which the wait time to see an emergency department clinician exceeds the recommended timeframe (USDHHS, 2011).

Participants, much like the U.S. Department of Health and Human Services, also wanted nearly all of these goals to be reached, as they recommended adopting a universal health care system, increasing prevention activities of individuals and families, focusing on prevention throughout the lifecycle, and teaching people when it is appropriate to use health care services such as the Emergency Department. It is not surprising that participants made similar recommendations, as health education specialists have made longstanding efforts to achieve the nation's ten-year goals set forth by the USDHHS (*Healthy People* documents; 2011).

Societal. Social factors that determine the health of the population are: social and physical determinants of health that reflect the social factors and the physical conditions in the environment in which people are born, live, learn, play, work and age....they impact a wide range of health, functioning and quality of life outcomes (USDHHS, 2011, Social section, para. 1).

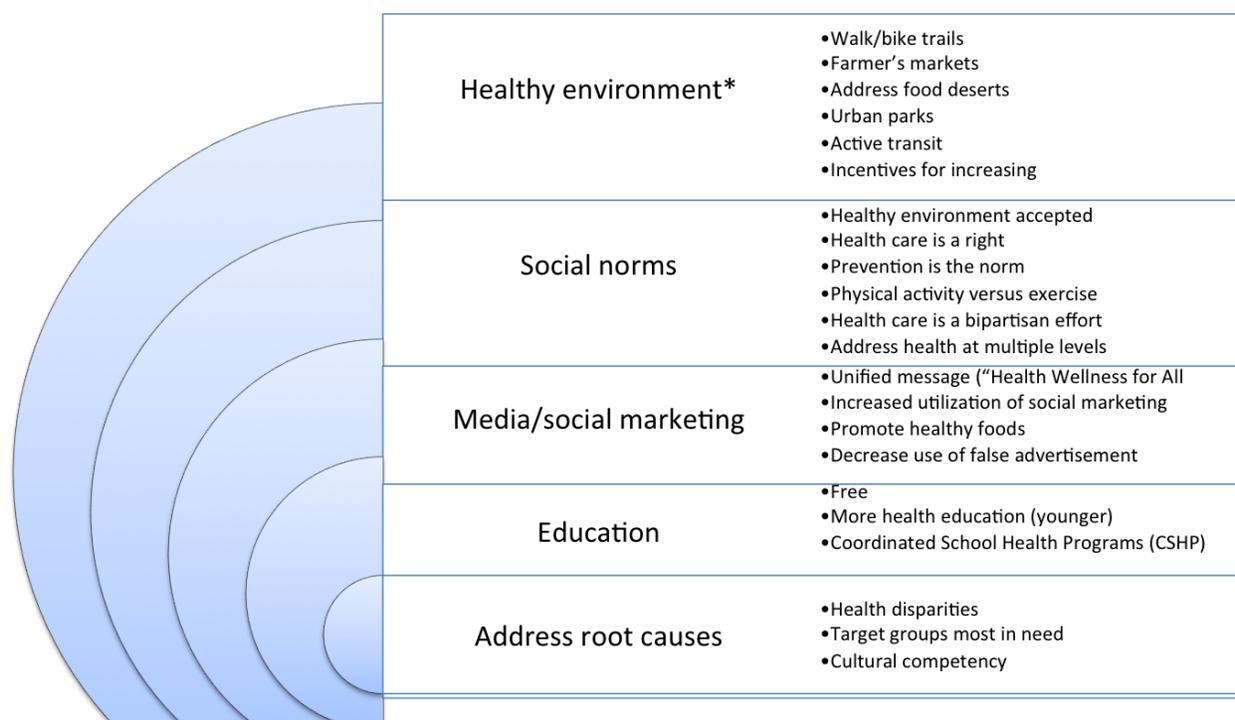
Social determinants can include availability of resources to meet daily needs, such as opportunities for accessing health insurance and health care, social norms and attitudes about

health care, exposure to mass media, socioeconomic conditions, etc. Societal factors also include physical determinants of health such as natural and built environments, health care settings, homes, physical barriers, etc. (USDHHS, 2011).

The major recommendation areas that emerged within the societal level include environment, social norms, and media or social marketing. Participants, also briefly mentioned education and addressing root causes, with an emphasis on health disparities and cultural competency issues. However, they are not included in this discussion of results, as they were not mentioned by a majority of participants. Figure 4 describes all recommendations mentioned within the societal level.

Figure 4

Societal Level Recommendations



Note. * represents a priority recommendation.

Healthy Environment. Many of the recommendations related to increasing healthy environments included increasing “urban parks, walking areas, and safe places, with less reliance on driving to encourage more physical activity.” A participant working in the post-secondary setting explained this area of recommendations in a similar fashion as many other participants:

We need to put some of our health reform emphasis on modifying the environment to encourage healthy behaviors. We need to make exercise easy and a part of one's life by initiating walk/bike trails. We need to make sure people have access to a variety of healthy foods by placing grocery stores close by and encouraging farmer's markets.

In addition, participants discussed the need for education regarding the importance of healthy environments in society as well as the need for these environmental changes to be accepted by everyone (to become a social norm). They believed that “most people don't understand how our environment impacts our health,” and they emphasized the importance of a healthy environment on the choices people make such as being physically active or eating healthy. They suggested building roadways that “allow for multiple means of transportation- bike, pedestrian, and car,” and increasing access to farmer's markets and grocery stores with fresh fruits and vegetables.

Social Norms. There also were many recommendations made regarding changes in attitudes and social norms in the United States. Although participants from all settings spoke about social norms, those working in the post-secondary setting mentioned the need for social norm shifts more than any other setting. Two of the most frequently made social norm recommendations were health care needing to be viewed as a right instead of a privilege and prevention needing to become the normal means for care versus treatment. A participant

working in the medical setting said that a necessary change would be an “attitude that health care is a right as opposed to a commodity that those who can afford it can obtain it.” In addition, participants believed that, “we also would need to address whether, as a society, we agree that all Americans should have access to health care, regardless of their income or sickness level, i.e. that health care is a right.”

A post-secondary participant offers a unique perspective as she remembered encounters with her students:

When I listen to students, who I would think would be more liberal due to their age, I'm astounded at their attitudes about "socialized medicine", about "those illegals getting care" and other horrific, not very public health sensitive, attitudes. That does not bode well for the future of health care reform! I try to help them recognize that from a PUBLIC health perspective and from an economic perspective, other people's health impacts on me. Therefore, it DOES matter if everyone is covered, if everyone is healthy, if everyone is immunized, etc. But, that lack of understanding is a real roadblock, I think.

Another recommendation was that prevention, rather than treatment, should also be a social norm as “we should be preventing illness, rather than treating it later.” Like many other recommendations, participants believed that having a prevention-oriented health care system would save health care dollars for the U.S. because “the U.S. spends more and has worse outcomes than any industrialized country in the world.” They thought that if prevention became the focus of the system then health care would cost less for everyone, and people would be able to “get their money’s worth.” They also thought that a social change focusing on prevention would lead to lifestyle changes that promote health. For example, many participants wanted people to be encouraged to increase their physical activity levels and eat healthier to prevent

chronic diseases. “We need to stop teaching 2-5 year-olds that eating fast food and candy on a daily basis is OKAY. We need to convince our kids that exercise and play are fun. It’s sad that kids need to learn that playtime is fun, but we stress the opposite by prioritizing video gaming.”

One group of participants focused on the issue of physical activity and its relation to playtime. A participant in the group stated:

That last comment about play involving exercise is a good one. I think, however, that the video gaming is something we could use and incorporate into our programs. Bob Gold had an idea to connect video games to exercise machines so that one generates the energy to play the video games through exercise.

As I reflected about this comment in my journal, I wrote:

That was an interesting idea about hooking video games to exercise equipment as many people, especially teens and young adults, have become quite sedentary as a result of sitting on the couch for countless hours to play their favorite video game. Perhaps this was a similar idea of the person who invented the Wii, and it was a huge success.

The last recommendation dealing with social norms was to view health care as a bipartisan effort. Participants believed that viewing health care in its currently viewed manner “only polarizes people in the issue.” They spoke about individuals using terms such as “Obama care” and the negative stigma associated with the use of such terms. Participants recommended the prohibition of using polarizing terms and the emphasis of all political parties coming together to speak about the need for health care reform as it affects every person.

Media/ Social Marketing. A final area of recommendations in the societal level was to change media influence and use social marketing techniques in health enhancing ways.

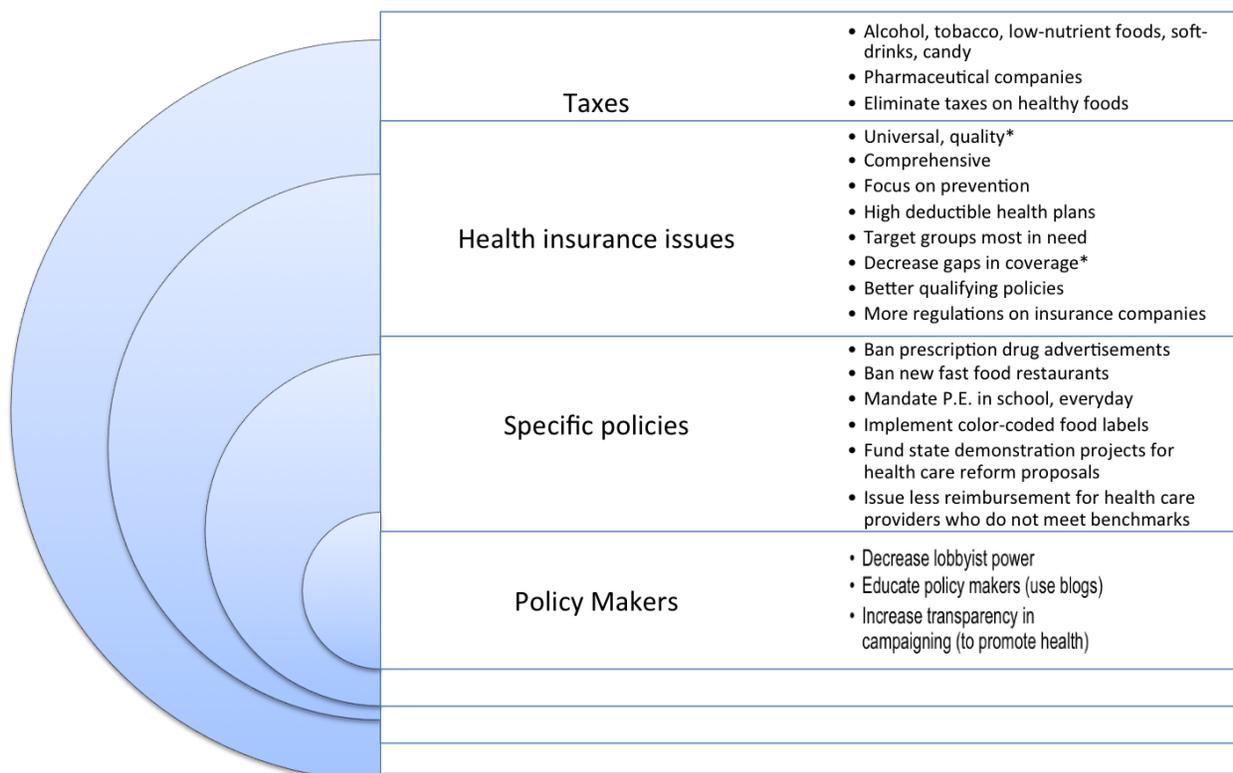
Participants believed that media and television strongly influence the behaviors of individuals.

They stated that “bad behavior is glamorized (drinking, partying, irresponsible behavior, risk-taking),” and they stressed that the majority of people in the U.S. prefer instant gratifications like entertainment and weight loss to adoption of a healthy lifestyle.

To remedy the negative influence of the media, participants proposed using social marketing techniques in health enhancing ways as they believed public health professionals have not yet utilized social marketing techniques in the most effective ways. Some participants liked the idea of creating a unified message such as “Health Wellness for All” and promoting the message via a social marketing campaign. Other participants particularly wanted to increase marketing of healthy fruits and vegetables instead of fast food restaurants and other unhealthy options. Finally, participants believed that social marketing campaigns could be used to “create a paradigm shift with the public to seek medical care and utilize prevention services.” They saw this type of social marketing campaign as an effective means of educating the public on the benefits of prevention and promoting an increase in prevention activity.

Policy. According to the USDHHS (*Healthy People 2020*; 2011), policy making includes “policies at the local, state, and federal level that affect individual and population health.” When asked, “are there any other policy changes that would need to pass for the reform plan to succeed, or to support it,” recommendations fell within four areas including increasing or decreasing certain taxes, health insurance issues, specific policies, and policymakers. Again, much like the health services recommendations, there was no difference in recommendations made based on gender, years of experience, or workplace setting. Figure 5 describes all recommendations mentioned within the policy making level.

Figure 5

Policy Making Level Recommendations

Note. * represents a priority recommendation.

Increasing/ Decreasing Taxes. The area of recommendations that emerged from the data the most was increasing or decreasing certain taxes. However, participants offered a variety of opinions regarding which taxes should be increased or decreased. Common taxes recommended to be increased were tobacco, alcohol, cigarettes, and foods low in nutrients, because participants believed that it is important to make unhealthy items less available to people and healthy items more readily available and affordable for people. Some participants suggested increasing taxes on foods low in nutrients, and one participant suggested using those taxes (such as taxes on soft drinks and candy) to pay for childhood obesity prevention programs. Other

participants recommended using increased taxes on unhealthy items to pay for environmental changes. For example, participants suggested using tobacco taxes for constructing bike paths in communities. They also suggested rewarding cities and communities for their construction of healthy environments (parks, tracks, bike paths) by decreasing their city taxes. Similarly, many other participants favored eliminating taxes on healthy foods, as this would make the healthier option more available to and affordable for the public.

Health Insurance Issues. Health insurance issues were another area of recommendations within the policy level. The general consensus that occurred while analyzing the data was “all Americans having insurance is a good first step, but it must be comprehensive insurance with good coverage, especially for preventive care.” Although the need for insurance was an idea that everyone could agree with, there was debate between a small number of participants regarding which entity should run a universal health care system (although the majority of participants did not mention, or seem to care about, who should be in control of a universal health care system). For the small number of participants who did disagree, the issue seemed to be over governmental control versus non-governmental control of the health care system. Those favoring governmental control had a belief that a private sector entity would have profits as a first priority and take advantage of the public. Those favoring non-governmental control had a belief that the government would have much trouble paying for a universal health care system, and they also believed that health care should not be something that is regulated by any government entity as health care should “remain a matter of individual choice.” Another debate occurred regarding the idea of high deductible health plans, where a participant in one focus group spoke in favor of the plans and many others disagreed with them. Although this was an issue that arose in only one focus group, I feel it is important to note because it illustrates that

there was not universal agreement on this issue. Nearly all participants in this focus group believed high deductible health plans would prevent people from getting screenings and other health services, but the participant in favor of the plans retained his opinion throughout the discussion.

A final recommendation regarding health insurance issues was to target population groups most in need (particularly the middle class population) with insurance policy, and to take into account common sense and special circumstances when deciding who qualifies for certain insurance plans. While the majority of participants agreed with this idea, some believed it would be hard to quantify or determine who would qualify for certain special circumstances. When discussing the issue one participant working in the medical setting offered a personal experience:

My stepfather is a farmer and doesn't have insurance at all for his family. He works 80 hours a week so they don't qualify for any assistance, but if he only worked 40 hours a week, they would qualify for government assistance. The government needs to rewrite the script for who qualifies for what and why, and also leave room for common sense and special circumstances.

Specific Policies. A third area of recommendations within the policy level focused on implementing or changing specific health policies. Some participants suggested implementing a policy to ban advertisements on prescription drugs because there is a “notion for some people that there is a drug for whatever ails you, rather than relying on lifestyle changes.” In addition, certain mandate policies were recommended. For example, some recommended mandating physical education in high school because students are not physically fit and not able to pass their fitness examinations. Participants wanted this mandate because “across the globe,

we are becoming known as ‘fat Americans’. I can't believe that children sit all day in school without physical activity.”

A very different recommendation involved increasing state involvement in determining the best method for health care reform policies or initiatives. However, a limitation was noticed regarding this recommendation as the political process sometimes prevents major changes such as this from occurring, and changes in government may prevent the recommendation from being fully carried out. A participant spoke of this idea:

Perhaps having some demonstration projects (perhaps at the state level) where waivers would allow a number of things to be tried would help. Some states might try the single payer route, some might emphasize a public health model, and some might try a market health insurance model. Then after five years, compare how these models are doing and implement at a national level.

Policy Makers. The final area for which recommendations were made within the policy level was geared toward policymakers; namely limiting power of lobbyists (because “corporations are lobbying against good health and health care reform”) and educating policymakers about health issues that need addressed (because “the aging population with many chronic conditions/diseases” will cost the U.S. a great deal of money). Many participants wanted to develop a blog/online forum to educate the President and First Lady about “significant structural changes that need to occur, and soon, before the aging population with many chronic conditions/diseases break the bank.”

This was a recommendation I thought to be outside the box. In my reflective journal I wrote:

This suggestion about an online blog to educate policymakers was innovative...outside the box ☺. I would not have thought of educating policy makers with anything other

than a white paper or position statement. I think this is a great idea because even politicians are education people with websites and technology, so why shouldn't health educators?

In addition, another innovative idea (in my opinion) was a participant's recommendation to focus on the early adopters, not the laggards, when trying to gain acceptance of a new health idea. While reflecting, I wrote:

I like the idea to focus on the early adopters, not laggards, to gain acceptance and promote healthy change. I have never thought of using Diffusion of Innovation for health care reform issues, but we have to market our ideas if we want to be successful. If it works for the retail industry, why shouldn't it work for the health industry.

However, participants could not ignore the difficulties in changing policy. They spoke of the power of money in the political arena and the fact that those individuals who need help the most probably do not have the amount of money needed to influence policy. However, they did believe health educators could come together in mass quantities to use their voice to influence the political process.

Research question one (From a health education perspective, what individual, health service, societal, and policy components should be in place for a health care reform plan to succeed) was a very broad question that resulted in a very broad answer. There were a number of recommendations made at each level of the *Healthy People 2020* determinants of health ecological model, and the recommendations discussed in this section were representative of the majority of participants. To reduce the large number of recommendations, participants were also asked to determine which recommendations were priorities, or should be addressed soon. The priority recommendations will be discussed later in this chapter.

Potential Roles of Health Educators

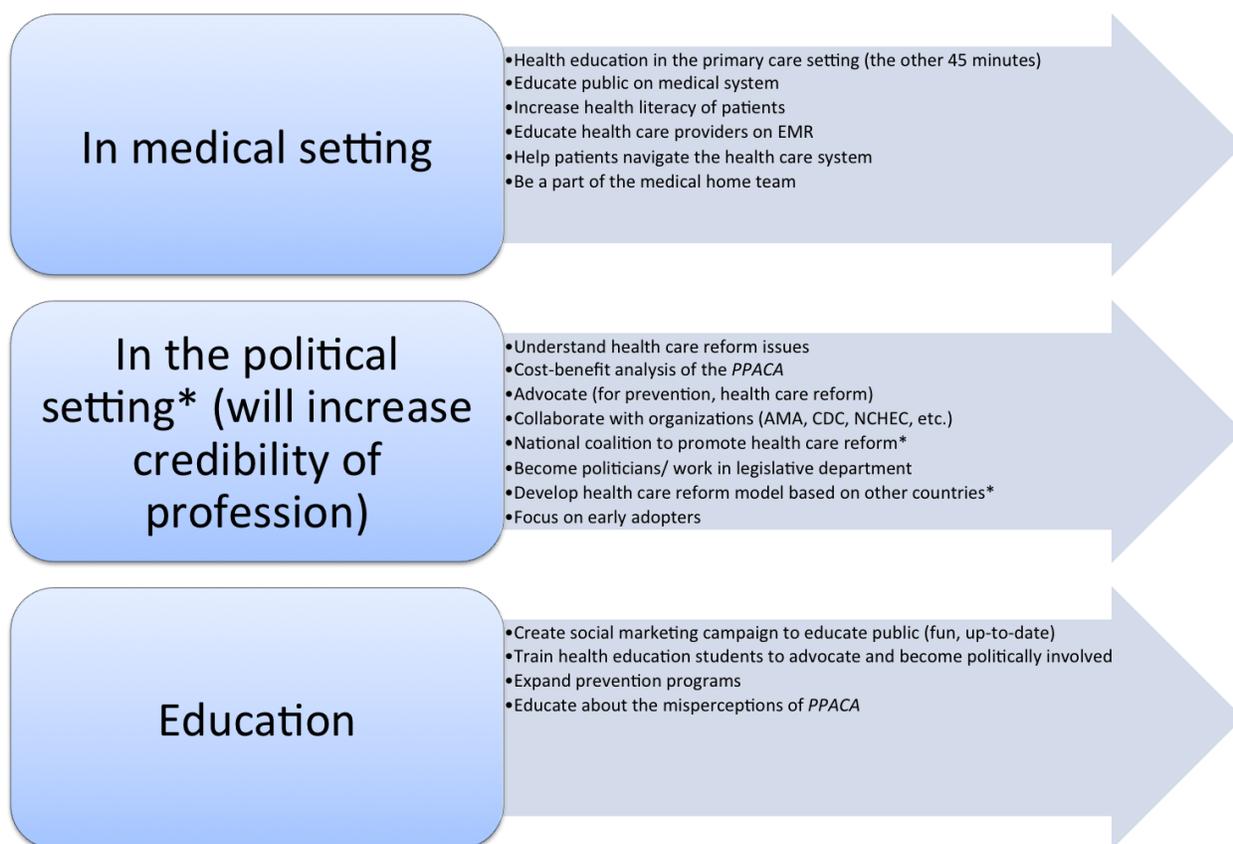
In addition to making recommendations at each level of the *Healthy People 2020* determinants of health ecological model, participants were also asked to describe what health educators might be able to do to aid in the enactment of the recommendations made. The responses provided fell within three areas: health educators in the medical setting, health educators in the political setting, and education. Again, there seemed to be no difference in recommendations made based on gender and years of experience, and participants in every workplace setting mentioned all of the major themes. The only differences noticed were the fact that participants in the medical setting seemed to be the ones to believe that a greater involvement of health educators in the political setting would increase the credibility of the health education profession. In addition, those working in the post-secondary setting spoke about the need for professional preparation programs to improve advocacy and policy training for health education students. Figure 6 describes all recommendations related to potential roles for health educators.

Medical Setting Involvement. Many participants believed “health educators could be better utilized in the primary care setting.” They thought “hourly wages are much less than having doctors go over anticipatory guidance and care plans, and patients could feel connected with someone (the health educator) who cares about them and takes time to speak with them.” In addition, participants spoke of “bridging the 45 minutes left over after the doctor sees the patient for 15 minutes.” Participant said the doctor could focus on treating the patient and answering medical questions related to the treatment, while health educators could focus on emphasizing healthy behaviors and health promotion. They discussed a variety of options such as one-on-one health education, group health education, assistance with navigating the health care system, and

literature on prevention activities. Some participants had a personal interest in becoming involved in the medical setting. A worksite participant stated, “I really enjoy this kind of stuff, so its something I would find valuable to do.”

Figure 6

Recommendations Related to Potential Roles for Health Educators



Note. * represents a priority recommendation.

Participants also recommended health educators should educate the public on issues related to the medical system. Some thought health educators should teach the public about when it is appropriate to use the Emergency Department. Others thought health educators could provide their services to increase health (and computer) literacy skills of patients, and they

thought health educators could also train physicians and medical professionals on how to utilize an electronic medical records system.

Political Setting Involvement. Another recommendation regarding health education involvement was to increase the presence of health educators in the political setting. Participants believed health educators should, first of all, become more knowledgeable about health care reform issues and the components of the *PPACA* (*PPACA*; Public Law 111-148). They also suggested becoming more involved in one of their professional responsibilities: advocacy. They recommended increased advocacy not only because it is a professional recommendation and “It is our duty to advocate for public health!,” but also because it would provide a way for health educators to become involved in the political setting without having to create policy themselves. They stated that health educators should “work with an advocacy group, visit your state legislature, talk to your legislators, and become involved. If you are a CHES, advocacy is one area we are told to be involved in, and get credit for.” Participants further proposed working with others (including groups like the American Medical Association) to advocate for positive health care reform changes to ensure prevention and health education are included in the health care system and reform proposals. Additionally, many participants recommended forming a national consensus group so the field of health education can “take the lead in making the case” that “health literacy and prevention should be at the top of the agenda.” They suggested health educators “invite people to talk about their health at home, at faith based organizations, at work, on the bus, in the mall, at football games...everywhere.” Yet another recommendation was to not just collaborate with and educate policy makers, but to “run for office ourselves.” A community participant suggested health educators work in “regulatory and

legislative departments to ensure health prevention measures and policies are drafted to be regulated.”

As stated previously, participants (especially those in the medical setting) saw a greater presence in the political arena as adding credibility and recognition to the profession itself. They saw a presence in the political setting increasing the “formality and credibility to health educators as a stand-alone profession.” Additionally, these participants also believed health care reform proposals would be more effective if they “integrated the patient in their care, policy and structure needs, and if they recognized health education as a stand alone profession that is integral to reducing costs in the health care system.”

Education. Education was a final recommendation area. The recommendations within this area involved educating the public about reform using social marketing campaigns as well as better educating health education students to become politically involved. Participants emphasized the ability of health educators to educate the public about health care reform issues, including misperceptions of health care reform proposals and ways in which health care reform proposals affect individuals’ lives. They saw an opportunity to “create social marketing campaigns and utilize effective educational strategies to explain what reform and prevention is and what it means for the health of the nation moving forward.”

Regarding professional preparation programs, participants wanted health educators working in the post-secondary setting to prepare “health education graduates to be proactive about health promotion at the institutional, governmental and individual level.” They thought that students should be given the skills to promote policy and the opportunity to engage in advocacy and policy experiences.

Priorities

Finally, I was interested in exploring the recommendations participants thought could, or should, be addressed soon. The majority of priorities offered by participants fell within the areas of insurance access and political involvement of health educators. In addition, involvement of health educators in the medical setting and health insurance coverage for health educators and mental health care were also less frequently mentioned priorities. While some of these priorities were mentioned more than others, they all emerged in almost every focus group. No differences in priority recommendations could be contributed to differences in gender, years of experience, and workplace setting.

Insurance Access. The most frequently made recommendation present in all focus groups and interviews was to provide universal health coverage for Americans with prevention also “covered universally for all,” so it was not surprising that it was also seen as a priority recommendation. A participant working in the medical setting most accurately described the views of nearly all participants:

I think universal healthcare and health insurance, which provides quality coverage at affordable cost, would be the biggest short-term aid to the poor, working poor, and middle class Americans. An emphasis on moving toward a preventive, wellness focused model would need to happen over a number of years.

In addition to universal health insurance coverage, participants also prioritized insurance coverage for health educators and for mental health care. A participant working in the medical setting believed a priority should be increasing access and coverage for mental health care, especially in light of the fact that mental health care carries a negative social stigma. In addition,

participants said “people tend to separate physical wellness from mental wellness. But really they are inextricably linked. Each one affects the other, and both are getting worse.”

Political Involvement of Health Educators. Another major area of priority recommendations was increasing involvement of health educators in the political setting. For example, participants thought it was a priority for health educators to advocate on a variety of issues. Some believed health educators should communicate and advocate about the misperceptions of health care reform as “there is a stunning amount of misperception about the law and its provisions. If this cannot be overcome, the risk is real that the law could be overturned.” Others believed health educators should advocate for mandatory physical education in schools. They believed “it would be fairly easy to do. You may have to increase the number of hours at school, but doing so would make it easier for parents/guardians.”

Finally, participants realized the importance of funding for all of the issues they spoke about, but they also realized there might be issues in attaining funding in the current economic climate. To illustrate the issue, one student spoke of her experience working on a project to promote screening for cervical cancer. She described that the clinic could perform the screening, but there was no funding for follow-up care for uninsured patients in instances where the screening results came back irregular. She stated, “We need to fix that if we want screening and preventative medicine to be effective, but that's going to be expensive. And, I have serious doubts about the American people's willingness to pick up the bill.” See Appendix N for a more detailed table of all predetermined categories, areas of recommendation, and specific recommendations.

Summary

Results regarding recommendations for health care reform in relation to the different levels of the determinants of health ecological model were provided in Chapter 4. Additionally, potential new roles identified as important for the health education profession in achieving an effective health care system were also explored. Overarching themes threaded throughout all levels of the *Healthy People 2020* determinants of health ecological model and recommendations included prevention, health literacy, and a focus on larger levels. Chapter 5 summarizes the study, along with providing conclusions, discussion, and recommendations for health education and for future research.

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Purpose of the Study

The primary purpose of this study was to explore recommendations from health educators for health care reform in relation to the different levels of the determinants of health ecological model. Additionally, this study examined the potential new roles participants identified as important for the health education profession in achieving an effective health care system.

Summary of the Study

Health care reform has been a controversial topic in America since the early 1900s (PBS, 2010). In fact, the Roosevelt, Truman, Johnson, Nixon, Reagan, and Clinton Administrations (Quadagno, 2005) all attempted to significantly change the health care system, illustrating the importance of health care to the American political system and the American public. While most of the attempts by presidential administrations to “fix” the health care system were brought down by interest groups or others with differing vested interests, one attempt to improve the health care system has succeeded (at least for now). On March 23, 2010, the *Patient Protection and Affordable Care Act (PPACA; Public Law 111-148)* was signed into law (USDHHS, 2010 & H.R. 3962). While there has been much controversy as to whether the *PPACA* (Public Law 111-148) is in the best interest of all Americans, many health educators would probably agree that access to health care should be a right of all citizens. The *PPACA* (Public Law 111-148) is an attempt to improve the current ailments of the U.S. health care system, and there are many. America spends more on health care than any other industrialized nation (National Center for Health Statistics, 2011). Despite spending more, we have many people who are unable to

receive health care. In 2009, the total number of uninsured Americans reached 46.3 million (CDC, 2009).

There was no research found examining health educators' beliefs and behaviors regarding health care reform issues, specifically, and limited research found regarding health educators' beliefs toward behaviors surrounding policy issues, in general. To date, only one study was located that analyzed health educators' behaviors related to health policy (Holtrop, Price, & Boardley, 2000). In addition, no studies were found using qualitative research designs to study health educators' experience with and recommendations for any policy issues, including health care reform issues. Due to the lack of existing research and the importance of health care reform to American society, I decided to conduct in-depth discussions with health educators regarding their beliefs about and recommendations for this policy issue. An interpretivist approach was used to gain contextualized, value-laden, specific knowledge from health educators to understand and interpret their perceptions about what needs to be in place on multiple levels for health care reform to be successful, including roles for the health education profession. The research methodology utilized in this study was theory-driven, using the *Healthy People 2020* determinants of health ecological model (USDHHS, 2011). Three research questions explored the following: 1) From a health education perspective, what individual, health service, societal, and policy components should be in place for a health care reform plan to succeed?, 2) What potential roles in health care reform do participants see for health education professionals?, and 3) How do health educators advocate or act on policy issues related to access to health care/ health care reform?

Participants included Certified Health Education Specialists (CHES) and Masters Certified Health Education Specialists (MCHES) who were committed to health care reform.

The study sample included 50 participants representing six selected workplace settings, both genders, and various years of experience in the field of health education. The largest group of participants (n=20) identified their workplace setting as post-secondary. Nearly half (n=21) of the participants indicated working in the field of health education for 6-15 years, and over half (n=36) of the participants were female.

Data collection methods included online, chat room focus groups and interviews. Data analysis involved sorting the data into predetermined categories according to the research questions and the *Healthy People 2020* determinants of health ecological model. Once data were categorized, each category's responses were sorted to identify overarching themes areas of recommendations; overarching themes and recommendation areas were organized topically; and rich, thick descriptions from the transcripts were utilized to give meaning to the findings. To ensure trustworthiness in this research, I utilized triangulation, member checking, adequate data collection, reflective journaling, peer reviewing, an audit trail, rich, thick descriptions, and maximum variation sampling (Merriam, 2009). Based on this analysis, three overarching themes and many recommendations emerged.

Conclusions

While many health educators have limited, if any, experiences in advocating for health issues, CHES and MCHES health education specialists who feel committed to health care reform issues have a variety of advocacy experiences. They also have a great deal of knowledge about the issues existing in the health care system, and they are able to draw from their advocacy experiences and knowledge to provide thoughtful recommendations for the health care system and for health care reform policies. Their recommendations emphasize addressing multiple levels/ determinants of health, with a focus on the larger levels (societal and policy) to make the

biggest changes. The health education specialists committed to health care reform issues also see a much larger role for the profession of health education in the health care system and the political arena, as illustrated by their priority recommendations for health educators. This group of health educators wants to see health care become a right for everyone, and they want prevention and health education to become a social norm in society and a visible component of health care reform policies in the U.S.

In addition, the emergent themes illustrated the importance of prevention to this group of health education specialists, as prevention seemed to link the majority of recommendations and all levels of the *Healthy People 2020* determinants of health ecological model. Participants not only believed that prevention was an important component of an effective health care reform proposal, but they also thought individuals needed knowledge about prevention services and the skills to engage in primary prevention. They believed all health professionals offering prevention services should be covered by health insurance, and they believed society should view the health care system as a prevention system instead of a treatment/ illness system. They recommended educating policy makers of policies that promote prevention, and the majority of priority recommendations also focused on prevention (advocating for prevention, universal health insurance with prevention coverage, etc.). Basically, the results of this study revealed the need for an increased emphasis on prevention, at multiple levels. There is a real need for our health care system to change into a system that does not focus on treatment after people get sick, but one that focuses on preventing illness and promoting wellness throughout the lifecycle and at multiple levels.

Discussion

After conducting this research on health care reform recommendations from certified health education specialists, I found that the results elicited information that was both expected and surprising. Discussion of these results and recommendations is organized according to research question.

Individual, health service, societal, and policy components that should be in place for an effective health care reform plan to succeed

Before making recommendations at each level of the *Healthy People 2020* determinants of health ecological model, participants were asked to describe the components of an effective health care reform policy. Their recommended components fell within three categories: prevention, access, and streamlining. Although the participants in this study were a very small percentage of the general U.S. population and an small group of health education specialists who felt committed to health care reform issues, it was a bit surprising to me that so many of the participants favored universal health care (it was even a priority recommendation). Generally, universal health care systems are run/ controlled by the federal government, and research polling American opinions on this topic has found that only 19% of Americans trust the government (CBS News, 2010). Therefore, it seems as though this group of health education specialists who feel committed to health care reform issues trusts the government more so than the general population. However, another study found that 60% of Americans thought the government should be responsible for ensuring U.S. citizens can meet their basic needs for health care (Kull, Galston, & Ramsay, 2009). There was one conversation about having a government-controlled health care system versus a privately controlled health care system. Although this was the only conversation concerning trust in government, making it appear that most participants did feel a

trust in government enough to allow them to run a universal health care system, it is possible that participants simply did not want to provoke an argument with others and so chose to avoid this topic. Another reason could be that they did not feel the rapport with participants that is needed to talk about such a personal, and political, topic.

A recommendation that seemed consistent with previous research fell within the streamlining category. Participants believed administration costs of the health care system should be reduced. They explored reasons for the high administrative costs including the complex system of insurance companies and the number of specialty physicians with private practices. Fuchs' (2009) research on this topic confirmed this recommendation as he stated that administration costs are an issue because the U.S. has hundreds of thousands of doctors, 50 states with different health care regulations, and hundreds of individual insurance companies.

Another recommendation that was found to be consistent with prior research fell within the individual level of the *Healthy People 2020* determinants of health ecological model. Participants in this study recommended individuals take a personal responsibility for their health care and become the primary person in charge of making health care decisions. They believed the public needed knowledge about health services available, but not so much as to overwhelm them; and they believed the public needed the skills to become proactive as they navigate the health care system. A study conducted by Hibbard and Cunningham (2008) also found that Americans are lacking in the knowledge, skills, and self-efficacy necessary to take an active role in promoting their health and accessing health care services. These recommendations are not surprising to me as health educators frequently communicate with the public in their work. They likely hear personal experiences from individuals who have limited knowledge about the health

care system, and therefore have a low level of self-efficacy and skills to make proactive decisions about their health and health care.

Not surprising to me was a recommendation falling within the health services category of the *Healthy People 2020* determinants of health ecological model. Many participants recommended an increase in the number of primary care physicians (PCPs), and this was consistent with research stating more physicians in the U.S. are specialists (Fuchs, 2009). In fact, less than one-third of all physicians are primary care physicians (U.S. Bureau of Census, 2009). Participants may have recommended increasing the number of primary care physicians for multiple reasons. One reason relates to the fact that, as stated previously, the growing number of specialist physicians in the U.S. contributes to higher health care costs and higher administration costs within the health care system. Another reason for recommending an increase in PCPs is that PCPs may be in a better position to educate patients on prevention services, to serve as a gatekeeper between patients and those performing prevention (and specialty) practices, and to increase rapport with patients to be better able to promote prevention services and health-enhancing, lifestyle changes.

Another recommendation falling within the health services level of the *Healthy People 2020* determinants of health ecological model was the recommendation to adopt an electronic medical records (EMR) system. This recommendation was likely to have been made by participants as it also aids in the reduction of administrative costs and promotes good communication among health care providers caring for the same individual, as well as promoting communication between the patient and his/ her health care providers.

The electronic medical record recommendation is also consistent with a current initiative of the *PPACA* (Public Law 111-148). The Improving Health Care through Health Information

Technology initiative is funded by the *American Recovery and Reinvestment Act* (Public Law 111-5; \$20 billion in five years), but the goals of this initiative are also goals of the *PPACA* (Public Law 111-148). They include improving quality of health care, preventing medical errors, decreasing paperwork, and decreasing costs (USDHHS, 2010). According to the Office of the National Coordinator for Health Information Technology (2011), health information technology allows health care professionals to always have accurate, complete patient records, to better coordinate care with other health care professionals through the use of electronic medical records, to share health information via the World Wide Web with patients and family members, to aid doctors in quicker diagnoses, to reduce medical errors, and to lower costs (Office of the National Coordinator for Health Information Technology, 2011).

Recommendations also were made within the societal level of the *Healthy People 2020* determinants of health ecological model. A recommendation made in this study was that health care should be a right. Nearly all of the participants believed health care should be a right for Americans, not a privilege. Conversely, eight hundred Americans were asked in a 2009 poll if they mostly thought health care was a right or a privilege, and 63% said it was a right (Kull, Galston, & Ramsay, 2009). It's not a surprising finding, as I stated in chapter one, because health educators in general have a vested interest in the health of the population and thus would agree that health (and access to health care) should be a right of all Americans.

Another recommendation made at the societal level was to adopt a health care model that focuses on prevention rather than a model focusing on treatment. This is a deviation from what is actually happening in the health care system, and what has been occurring for years. Hoffman, et. al. (2009) stated that the American health care system operates as an entity that treats acute illnesses, rather than preventing them from happening. The health education specialists who

participated in this study likely believed that a prevention-oriented health care system would focus more on health (a major emphasis of the field of health education) rather than illness.

In addition, the recommendation to not simply focus on individual level recommendations and instead focus on environmental and population changes to make the biggest difference in the health of society is consistent with evidence provided by the USDHHS (2010) stating that targeting multiple levels increases the likelihood of successful behavior change. However, it seems inconsistent with the approaches health educators typically use. Other research suggests health educators typically develop interventions or programs that target primarily individual level behaviors (Holtrop, Price, & Boardley, 2000 & Freudenberg, 2006). And, many of these individual level behavioral interventions have failed to improve the health status of participants, which illustrates the need to think of health education on a broader scale (Schneider & Stokols, 2009). Freudenberg (2006) speaks of why it is important to think about health issues from an ecological approach.

The major causes of death today are heart disease, cancer, stroke, accidents, and violence. Each of these conditions is firmly rooted in our country's social structure. To address only the behavioral manifestations of our social ills, without touching their political and economic determinants, is like treating the symptoms of cancer as the tumor grows...if one defines health education more broadly – as those efforts that educate and mobilize people to create more healthful environments, institutions and policies (as well as lifestyles) – one can find a rich tradition of health education for social change (Freudenberg, 2006, p. 65).

Perhaps an increase of health educators in the health care system would promote a prevention-oriented approach to health care that addresses health issues at multiple levels.

The last set of recommendations fell within the policy level of the *Healthy People 2020* determinants of health ecological model. Consistent with research on health care reform recommendations from other professions, health education specialists participating in this study found expanding access to health insurance to be a priority. The most frequently offered recommendation by five professional groups was to expand access to health insurance coverage (American Academy of Family Physicians, 2011; American College of Physicians, 2011; Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009). This was an essential reform for these professions because access to coverage improves the health of Americans (American Academy of Family Physicians, 2011). And, expansion of access would not only improve the health of Americans, but it would also likely increase the global competitiveness of the U.S. (HR Policy Association, 2009). While health education specialists may not want to increase access to health care in order to increase global competitiveness, they still believe access to health care is essential to improving the health of Americans.

Finally, it is important to note that recommendations in this study were also consistent with common recommendations made by other professions. Other common recommendations made by professions include containing costs, establishing and promoting Exchanges (which is a transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans; USDHHS, 2011), investing in health information technology (HIT), and promoting collaboration. All of these recommendations were also made by health education specialists, except the recommendation to promote Exchanges. Containing costs may be achieved by reducing administrative costs, focusing on prevention, paying based on quality of care or outcome measures instead of fee-for-service, or managing

costs by all stakeholders (American Academy of Family Physicians, 2011; Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009). HIT includes electronic medical records, electronic prescribing, messaging, etc. The benefits of HIT include a decrease in administrative costs, promotion of data exchange, promoting adherence to “best practices,” promoting prevention and treatment, and increasing quality of care (American Academy of Family Physicians, 2011; Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009). Promoting collaboration across fields and sectors is a recommendation to strengthen and improve the health care delivery system as a whole. The patient-centered medical home model is one way of improving collaborative efforts by using a team-based approach to medical care that provides preventive services, treatment, and end-of-life care (Arrow et. al., 2009; GlaxoSmithKline, 2009; RWJF, 2009). The other professions recommended Exchanges so people who cannot afford or do not have access to group insurance plans will be able to have access to affordable insurance. Also, the Exchanges will help to protect the American public from the catastrophic financial burden from illness while promoting prevention (Arrow et. al., 2009; GlaxoSmithKline, 2009; HR Policy Association, 2009; Maves, 2010). One reason for the absence of this recommendation in my study may be that most health educators do not think of health care in terms of economic factors, which was the basis of supporting the Exchanges by the other professions.

Potential new roles for health education professionals in health care reform

Results pertaining to potential roles of health educators in health care reform fell within three areas: involvement in the medical setting, involvement in the political setting, and education. One of the recommendations made for involvement in the medical setting was for health educators to aid in teaching patients when to use health care services such as emergency

departments. This recommendation was consistent with Fuchs' (2009) research as he found that lack of social support for poor, uneducated Americans causes emergency department use to rise, resulting in health care costs rising for everyone else. Again, this is not a surprising result as health educators frequently communicate with the public in their work. They likely hear personal experiences from individuals who have limited knowledge about the health care system, and therefore do not use health care services, such as emergency departments, appropriately.

Of the two articles I could find relating to policy involvement of health educators, both emphasized the need for health educators to be involved in policy activities (Cooper, 1986; Holtrop, Price, & Boardley, 2000), which was a priority recommendation in this study. One reason for this as a priority recommendation is likely that health education specialists realize the need to put pressure on key influentials, including policy makers, to make a significant health-related change. One example is smoking. Without the policies and regulations preventing people from smoking in public places, the percentage of those who smoke likely would not have dropped so significantly in recent years. A California politician spoke about the need for advocacy in public health:

When you look back on key legislative fights over public health issues, you will see that the expertise and advocacy of public health professionals provide a critically important counter pressure to the lobbying clout of special interests. The grassroots efforts by the public health community help educate legislators and play a pivotal role in our legislative efforts to improve the health of the people of the United States (APHA, 1999, p. 1).

Advocacy efforts of health education specialists related to access to health care/ health care reform

Information was also gathered to see how participants advocated for health issues. This study found health educators to be quite involved in advocacy (which is a policy activity) when Holtrop, Price, and Boardley (2000) found, in their research, that health educators were involved in policy activities, but many were only involved in two or fewer policy activities across a two-year span. This is not surprising to me, however, because a requirement criterion for this study was to feel a commitment to health care reform. If a person feels committed to an issue, it is reasonable to say that they would be more apt to advocate for it than one who feels no commitment.

An additional point to make on the topic of advocacy experiences includes the fact that the interview question asked during focus groups and interviews did not completely reflect the research question. The interview question stated “what experiences, if any, do you have advocating for health or health education” while the research question stated “how do health educators advocate or act on policy issues related to access to health care/ health care reform.” Although the two questions did not elicit the same information, participants still frequently referred to health care reform advocacy experiences when they discussed the interview question.

Discussion of Participants

Finally, there are a few comments to be made about the participants in this study, particularly dealing with the characteristics of interest. The characteristics of interest for this study were being committed to health care reform, workplace setting, years of experience in the profession, and gender. I believed that health educators with differences in these characteristics were likely to provide different recommendations for health care reform. First and foremost, the

sample of health educators selected to participate in this study needed to be committed to health care reform. As the researcher, I believed those health educators who were committed to health care reform would be better able to provide in-depth, thoughtful recommendations for health care reform and the potential roles for health educators within the health care system. Workplace setting (community, medical, post-secondary, school, worksite, organization/foundation, and government), years of experience in the profession, and gender were characteristics of interest chosen based on the results of the Holtrop, Price, and Boardley study (2000). Their study revealed that there were no statistically significant differences in involvement of policy activities based on level of education and race/ ethnicity. However, there were significant differences when looking at age, employment setting, and gender/ sex. Basically, their study found that older health educators, male health educators, and health educators working in government settings were more likely to report involvement in policy activities. Although this study did not focus on measuring policy activities of health educators, it was still thought to be of value to look for differences in recommendations of health educators in these different characteristic groups because their personal experiences and attitudes about policy will certainly affect the types of recommendations they provide. Based on the results of this study, however, there seemed to be no difference in recommendations made based on years of experience in the profession and gender. Workplace setting, on the other hand, did result in different types of recommendations. For example, those working in the medical setting sometimes provided recommendations more medical in nature such as the need for better prevention education for primary care physicians.

Also, I think a characteristic of interest that could have been added (and could be added in future studies on this topic) is political party because nearly all participants favored universal health care, and as Peters (2008) stated, Democrats usually promote spending on social issues

(including health care) while Republicans generally think government should not interfere with or spend funds on social issues. It would be interesting to see if the majority of participants were Democrats, or if they simply favor universal health care because of their passion for health. Finally, I found it interesting that there was a lack of representation from health education specialists in certain workplace settings. Only 6 people identified their workplace setting as medical, while 4 identified their workplace setting as organization/ foundation or worksite, and only 2 identified their workplace setting as school. An explanation for this is likely to be that these are the workplace settings that the least numbers of health educations tend to enter.

Limitations of the Data Collection Process

The data collection process contained several limitations worth noting. The primary issue was the large number of people who failed to join the focus group after agreeing to participate. After solicitation was completed, 200 certified health educators indicated an interest in participating in the study. After those 200 people were emailed requesting selection of a date and time to attend a focus group, just over half (n=109) were still willing to participate. Sixteen focus groups were scheduled, but two had to be cancelled due to lack of attendance, and two focus groups turned into interviews as only one person attended. So, 12 focus groups and 2 interviews were held during the data collection process with a total of 50 certified health educators participating. Despite the fact that multiple reminders were sent to each participant, the attendance percentage ranged from only 14.29% to 75.00% of participants who agreed to participate in a particular focus group present. Perhaps the biggest reason for the lack of attendance can be attributed to the online process itself, as there seemed to be no accountability or perceived personal responsibility to attend. A few participants emailed either before or after the scheduled focus group to notify me why they were not able to attend, but the vast majority

did not. The participants did not know me and are likely to never see me in the future; therefore, the consequences of not attending the focus group were very minor, if present at all. I suspect the attendance rate would not have been so low if the focus groups were conducted face-to-face.

Another reason for the lack of attendance can be contributed to technical problems participants had with accessing the website (<http://host7.parachat.com/hosted/index.html?site=30755&room=Do-you-feel-a-COMMITMENT-to-health-care-reform&width=600&height=400>). I selected the Parachat® software on the basis that participants would not be required to download additional software to participate. However, Java® was actually required, but only one participant notified me that she had to download Java® before signing in. The greatest technical problem reported was that the website turned out to be restricted on some of the participants' work computers. In an attempt to determine why participants were having technical problems signing into the focus group website, I contacted Parachat® customer support, and they informed me that sometimes websites containing "chat" in their text are programmed to be blocked by a workplace's computer administration team. The remaining participants were notified of this issue, but eight people were still not able to access the website.

The other issue pertaining to the data collection process was simply that there was not enough time allotted to answer all of the interview questions in-depth. One explanation for this, again, was the lack of attendance. Because there were frequently only one or two people present at the start time, it was often necessary to wait a minute or two before beginning to allow for other participants to log in. And, with only 50 minutes to complete the focus group, a few minutes became significant. Also, there was a total of eight interview questions that needed to be asked to fully answer each research question along with demographic data to be collected, so

on average that only allowed six minutes and fifteen seconds for each question (without allowing for time to wait for participants, answer questions, or obtain demographic data). As a result, I found the online focus group process to be consistent with Schneider, et. al.'s (2002) findings in that my participants contributed shorter comments than I expect they would have in a face-to-face setting, and those comments seemed to be uniform in level of participation, meaning no one participant dominated the conversation. I was pleased that no one dominated the conversation during the focus groups, however, I found myself wishing for additional time to continue discussion toward the end of every focus group session. Some of the focus groups did not end after just 50 minutes if conversation was flowing and participants kept discussing the topic. However, during some focus groups (especially those conducted during the hours of 8:00 a.m.-5:00 p.m.) participants needed to log out in exactly 50 minutes in order to make it to a meeting, class, etc.

A final issue with data collection concerned the levels of the *Healthy People 2020* determinants of health ecological model. Participants were asked to determine what was needed on individual, health services, societal, and policy levels for their health care reform plan to be effective. Although participants gave great recommendations for each level, many times when I asked about a certain level, the recommendations they gave pertained to various other levels. One reason for this could have been that they were simply trying to discuss all of the recommendations they could think of, or that they were still contemplating recommendations at levels previously discussed. However, it seemed as though discussion may have been more in-depth if the conversation could have been focused at each level.

Recommendations for Improving the Data Collection Process

1. To obtain a higher participation rate, include a wider variety of date/ time choices as well as including the available choices in the solicitation email. By doing this, the researcher will be able to obtain a more detailed forecast of interested participants who are available to participate during the chosen dates/ times.
2. To obtain a higher participation rate, it may be better to utilize an audio-visual chat room, so participants can actually see the researcher. Although this action may require additional software to be downloaded (providing another obstacle to participating), it may increase the accountability/ personal responsibility of participants for attending the focus groups.
3. To obtain a higher participation rate, utilize chat room software that does not contain “chat” in the website’s text. If this is not possible, be sure to notify participants that the website could be blocked on their work computers, and encourage them to practice accessing the website from the computer they plan to use when attending the focus group to ensure they can indeed log in. If they do get blocked from the website, encourage them to use a personal computer or request permission from their workplace’s software administrator to remove the access restriction.
4. To improve the data collection process, allow additional time during the focus groups (I would recommend 60-90 minutes) so all interview questions can be thoroughly discussed. Other possible solutions, if additional time cannot be allotted, may be to collect demographic data via email either during the solicitation process or after the focus group, and to start the focus groups exactly at the proposed start time without waiting for additional participants to join.

5. To improve the data collection process, provide participants with a description of each level of the *Healthy People 2020* determinants of health ecological model before the focus group. This will hopefully keep the discussion focused and on topic during data collection, allowing for a more in-depth discussion.

Recommendations for Health Education

Health educators have a responsibility to advocate for health, health education, and health policies. The following are recommendations for the field of health education based on the results of this study. The recommendations include ways to impact health care reform policy, methods for marketing recommendations to the public and to policymakers, recommendations for increasing advocacy activity regarding health care reform issues, and methods for improving professional preparation programs and their ability to educate students about health care issues and advocacy techniques.

1. With the results of this study, compile priority suggestions/ recommendations into a position statement/ white paper in order to influence policy makers and politicians in Washington D.C. (and in local communities). Present the white paper on Advocacy Summit Day in Washington D.C. as well as sending it to the health committees in Congress; the health care committee (chairman: John D. Rockefeller) and the health, education, labor, and pensions committee (chairman Tom Harkin).
2. Publish priority recommendations in informal publications such as magazines (ex. *Time* and *Newsweek*) and newspapers (ex. *New York Time*, *Washington Post*, *Chicago Tribune*, *USA Today*) to educate the public and market for change.
3. Fulfill new professional roles in the strained health care system by educating and developing resource materials for the 32 million newly insured Americans that will gain

health insurance access in 2014. Possible topics for resource materials could include a comparison of health insurance options, guidelines for recommended screenings, skills for increasing health literacy, prevention activities for various target populations (ex. elderly, women, children), and misperceptions of the *PPACA*.

4. Develop an online personal health navigator for the public to use as an aid in understanding and navigating the health care system (ex. explain insurance options, provide enrollment assistance, provide prevention education, list screening guidelines, address misperceptions about health care reform proposals, etc.).
5. Form a national coalition to develop a unified, prevention-oriented health message to promote health care reform issues. Utilize up-to-date, fun social marketing techniques that focus on the early adopters to create a social change that encompasses health care for all, prevention, and health literacy. Also collaborate with influential groups such as the AMA and CDC to gain recognition and increase the rate at which the health message is spread and adopted.
6. Join professional organizations that advocate for health issues such as AAHE, ASHA, and APHA. Get involved in their advocacy opportunities such as writing advocacy letters to local Congressmen, attending advocacy summits, and participating in advocacy training sessions.
7. Request/ apply to work with the National Prevention, Health Promotion, and Public Health Council (funded by the *PPACA*; Public Law 111-148) to provide recommendations to the Congress and President Obama regarding evidence-based strategies to increase prevention, wellness, and health promotion (42 U.S.C.A., 2010).

This will not only help health educators to become a major stakeholder in health care reform issues, but it will also add credibility to the profession.

8. Apply for funding through the \$250 million allocated by the *PPACA*'s (Public Law 111-148) Public Health Fund, which was created to boost clinical and prevention initiatives such as anti-obesity programs and public health research. Look for funding and applications on the U.S. Department of Health and Human Services website <https://grants.hrsa.gov/webExternal/fundingOpp.asp> (USDHHS, 2012).
9. Professional preparation programs should assign a segment of the curriculum to include education about health care reform issues. Health care reform is a topic that will continue to be controversial in the U.S., and it should be of interest to health educators because health care reform policies affect the health of everyone. Possible courses to include curricula regarding health care reform issues could include Contemporary Issues in Health Education, Community Health, and Program Planning and Evaluation (with an option to develop a community program that increases access to health care for a target population).
10. Professional preparation programs should develop an advocacy-training program to prepare health education students to advocate on various topics, including health care reform issues. The training program should include skills necessary for advocacy activities including writing an advocacy letter, developing a policy brief and white paper, conducting a policy analysis, and designing an advocacy campaign.
11. Professional preparation programs should provide experiential learning opportunities to students where they actually get the chance to advocate for health care reform and other health issues. Examples of advocacy activities may include having mock advocacy days

or scenarios where students engage in advocacy communication about selected topics, holding meetings with elected officials sponsored by students or student organizations like Eta Sigma Gamma, and writing letters to elected officials and school newspapers to advocate about health care reform and other health-related topics.

Recommendations for Future Research

The following recommendations provide an outline for future research related to health education advocacy for health care reform issues.

1. Determine the barriers to addressing health issues using multi-level, or ecological, approaches. When asked what individuals needed for a health care reform plan to be successful, many participants stated the need to focus on higher levels (such as societal and policy) rather than focusing on the individual level. However, research has shown that multi-level approaches are not commonly used to address health issues. A study determining perceived barriers to addressing health issues using multi-level approaches may help to determine why these approaches aren't used, and the results can be used to develop a program to address the barriers and develop the skills needed to utilize multi-level approaches.
2. Conduct research similar to this, but elicit recommendations from a larger group of health educators with different levels of commitment to health care reform issues. Focus groups could be conducted at professional conferences or with members of various professional organizations. It also may be interesting to include political party as a characteristic of interest as it might help to explain, or provide context, some of the participants' responses.

3. Conduct a Delphi study as a follow-up study to further prioritize and finalize recommendations for the health care system at each level of the *Healthy People 2020* determinants of health model. If recommendations are further prioritized and finalized, they will be more representative of the profession as a whole, and a position statement can be drafted and supported by one of the professional organizations such as NCHEC or AAHE.
4. After priority recommendations are finalized, determine specific action plans/ methods for achieving the priority recommendations. The action plans could then be used to more easily educate and influence policy makers to include the professions' recommendations in their health policy proposals.
5. Research what types of experiences health education specialists perceive to be influential in becoming committed to health care reform issues, and use the results to inform professional preparation programs and advocacy training programs by providing students with similar types of experiences.
6. Conduct research at the medical setting to determine to what extent, if at all, medical professionals (especially primary care physicians) could incorporate health education, health educators, and prevention education as part of their regular medical practice.

Final Thoughts

Advocacy is a professional responsibility for all health educators, and while it may be true that only a select group of health educators have a passion for advocating for any health issue, there is a group of health educators who truly have a passion for health care reform and are willing to invest the time and energy into advocating for health care as a right for all. I believe that health care can be a right that is achieved for all, there are actions that can be taken by health

educators to aid in reaching this goal. Health educators- become involved in professional organizations that advocate, join a coalition, take a continuing education unit to learn about health care reform or advocacy, write/ visit your local legislators, and encourage others to do the same! I was inspired by a participant's statement, and hope that it will inspire more health educators to become committed to health care reform and act on their commitment:

I feel I am committed to health care reform. It is important because so many people are without it, or they have to choose between healthcare and buying food for their families. Others have gone bankrupt paying health care costs. I think everyone deserves health care, not just those who can pay for it. It is a human right, not a privilege.

References

- Agency for Healthcare Research and Quality. (2004). *National healthcare disparities report: Summary*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from <http://www.ahrq.gov/qual/nhdr03/nhdrsum03.htm>.
- Agency for Healthcare Research and Quality. (2009). *National healthcare disparities report, 2008*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved from <http://www.ahrq.gov/qual/nhdr08.pdf>.
- Almanac of Policy Issues. (2010). *Medicare*. Retrieved from <http://www.policyalmanac.org/health/medicare.shtml>.
- American Academy of Family Physicians. (2011). *Principles for reform of the U.S. health care system*. Retrieved from <file:///Volumes/NO%20NAME/6%20AAFP%20Principles%20for%20Reform%20RECOMMENDATIONS.webarchive>.
- American Alliance for Health, Physical Education, Recreation, and Dance. (2011). *Join HEAL*. Retrieved from <http://www.aahperd.org/aahe/advocacy/HEAL.cfm>.
- American College of Physicians. (2011). *Medicaid and health care reform: A position paper of the American College of Physicians*. Philadelphia, PA: American College of Physicians.
- American School Health Association. (2011). *Advocacy coalitions*. Retrieved from <http://www.ashaweb.org/i4a/pages/index.cfm?pageid=3304>.
- American School Health Association. (2011). *Advocacy network*. Retrieved from <http://www.ashaweb.org/i4a/pages/index.cfm?pageid=3306>.
- Anderson, G. F., and Markovich, P. (2008). Multinational comparisons of health systems data, 2008. *The Commonwealth Fund*.

- American Public Health Association. (1999). *APHA advocates' handbook: A guide for effective public health advocacy*. Washington DC: American Public Health Association.
- Arrow, K. J., et. al. (2009). Toward a 21st-century health care system: Recommendations for health care reform. *Annals of Internal Medicine*, 150(7). Retrieved from http://healthpolicy.stanford.edu/publications/toward_a_21stcentury_health_care_system_recommendations_for_health_care_reform/.
- Barry, P. (2010, May). A user's guide to health care reform. *AARP Bulletin*. Retrieved from http://www.bulletin.aarp.org/health_care.
- Batra, C. (1992). Empowering for professional, political and health policy involvement. *Nursing Outlook*, 40(4), 170-176.
- Baucus, M. 2008, November 12. Re: Call to action: Health reform 2009 [Online forum comment]. Retrieved from <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>.
- Becker, H. S. (1970). *Sociological work: Method and substance*. Chicago, IL: Aldine.
- Blendon, R. J., Brodie, M., and Benson, J. M. (1995). What happened to Americans' support for the Clinton plan? *Health Affairs*, 12(2), 7-23.
- Blumenthal, D. and Morone, J. (2009). *The heart of power: health and politics in the Oval Office*. Berkeley, CA: University of California Press.
- Bosso, C. J. & Collins, M. T. (2002). Just another tool? How environmental groups use the internet. In Cigler, A. J. & Loomis, B. A. (Eds), *Interest group politics* (6th ed.). Washington DC: CQ Press.

- Brodie, M., Altman, D., Deane, C., Buscho, S., and Hamel, E. (2010). Liking the pieces, not the package: Contradictions in public opinion during health reform. *Health Affairs*, 29(6), 1125-1130.
- Capwell, E. M. (2004). Coalition of national health education organizations. *California Journal of Health Promotion*, 2(1), 12-15.
- CBS News, New York Times. (2010, February 5-10). *The president, congress, and dissatisfaction with government [poll]*. Retrieved from http://www.cbsnews.com/htdocs/pdf/poll_Obama_Congress_021110.pdf.
- Centers for Disease Control and Prevention. (2009). *Health insurance coverage*. Retrieved from <http://www.cdc.gov/nchs/fastats/hinsure.htm>.
- Centers for Medicare and Medicaid Services. (2010). *Medicare and the new health care law - What it means for you [Brochure]*. CMS Product No. 11467.
- Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. (2009). Retrieved from <http://www.cms.hhs.gov/NationalHealthExpendData/>.
- Central Intelligence Agency. (2010). *The world factbook*. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html>.
- Congressional Budget Office. (2007). *The long-term outlook for health care spending*. Washington DC. Retrieved from <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf>.
- Cooper, C. E. (1986). Political knowledge and participation of health education students. *Health Education*, 10-13.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

- Davis, C. S. & Somers, S. (2011). National health care reform and the public's health. *Journal of Law, Medicine, and Ethics, Spring*, 65- 68.
- Davis, K., Schoen, C., & Stremikis, K. (2010). The Commonwealth Fund, Mirror, mirror on the wall: How the performance of the U.S. health care system compares internationally, 2010 update. Retrieved from http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/June/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf.
- Delli Carpini, M. X. & Keeter, S. (1996). *What Americans know about politics and why it matters*. New Haven and London: Yale University Press.
- DeNavas-Walt, C., Proctor, B.D., & Smith, J., U.S. Census Bureau. (2010). *Current population reports, income, poverty, and health insurance coverage in the United States: 2009*. Washington DC: United States Government Printing Office.
- Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods* (2nd ed.). New York: McGraw-Hill.
- Druss, B. G., Marcus, S. C., Olfson, M., et. al. (2001). Comparing the national economic burden of five chronic conditions. *Health Affairs*, 20(6), 233-241.
- Duffy, J. (1971). Social impact of disease in the late 19th century. *Bulletin of the New York Academy of Medicine*, 47, 797-811.
- Feldstein, P. J. (2007). *Health policy issues: An economic perspective* (4th ed.). Chicago, IL: Health Administration Press.
- Foundation for Accountability. (2001). *Portrait of the chronically ill in America, 2001*. Portland, Oregon: The Foundation for Accountability, and Princeton, New Jersey: The Robert Wood Johnson Foundation.

- Freudenberg, N. (2006). Training health educators for social change. *International Quarterly of Community Health Education*, 25(1-2), 63-77.
- Fuchs, V. R. (2009). Cost shifting does not reduce the cost of health care. *JAMA*, 302(9), 999-1000.
- Fuchs, V. R. (2009). Health care reform: Why so much talk and so little action? *New England Journal of Medicine*, 360, 325-327.
- Gallup, Inc. (1994). *Public opinion poll, April 16-18, 1994*. Retrieved from <http://www.gallup.com/poll/27208/americans-more-favor-heavily-taxing-rich-now-than-1939.aspx>.
- Gallup, Inc. (1996). *Public opinion poll, January 1996*. Retrieved from www.gallup.com.
- Gelman, A., Lee, D., and Ghitza, Y. (2010). Public opinion on health care reform. *The Forum*. Berkeley Electronic Press.
- GlaxoSmithKline. (2009). *GSK supports comprehensive health care reform in the U.S.* Retrieved from <http://us.gsk.com/docs-pdf/healthcare/GSK-healthcare-reform-position-paper.pdf>.
- Harvard School of Public Health, Kaiser Family Foundation. (1994). *Kaiser health tracking poll*. Retrieved from www.kff.org/kaiserpolls.
- Harvard School of Public Health, Kaiser Family Foundation. (2003). *Kaiser health tracking poll*. Retrieved from www.kff.org/kaiserpolls.
- Health Care Lawsuits [Web site]. (2010). *Cases by legal argument: 10th amendment*. Retrieved from <http://healthcarelawsuits.org/case-tenth amendment.php>.
- Health Resources and Services Administration. (N.D.). *What is a health center?*. Retrieved from <http://bphc.hrsa.gov/about/>.

- Heaney, M. T. (2004, September 2-5). *Reputation and leadership inside interest group coalitions*. Paper presented at the meeting of the American Political Science Association, Chicago, IL.
- Heritage Foundation. (2011). *Leadership for America: Health care*. Retrieved from <http://www.heritage.org/initiatives/health-care>.
- Hibbard, J. H. & Cunningham, P. J. (2008). How engaged are consumers in their health and health care, and why does it matter? *Center for Studying Health System Change Research Brief, 8*, 1-9.
- Hoffman, C., et. al. (1996). Persons with chronic conditions: Their prevalence and costs. *Journal of the American Medical Association, 276*(18), 1473-1479.
- Holtrop, J. S., Price, J. H., & Boardley, D. J. (2000). Public policy involvement by health educators. *American Journal of Health Behavior, 24*(2), 132-143.
- HR Policy Association. (2009). *Recommendations for essential elements of health reform from an association of large employers who cover more than 10 million Americans and purchase more than \$75 billion of health care annually*. Retrieved from <http://www.hrpolicy.org>.
- Institute of Medicine. (2004). *Health literacy: A prescription to end confusion* (Report brief). Washington DC: National Academy Press.
- Institute of Medicine. (1990). *Medicare: A strategy for quality assurance* (Vol. 2). Washington DC: National Academy Press.
- Institute of Medicine, National Academy of Sciences. (1988). *The future of public health*. Washington DC: National Academy Press.

- Jacobs, L. R. & Skopol, T. (2010). *Health care reform and American politics: What everyone needs to know*. New York, NY: Oxford University Press.
- Joint Committee on Health Education and Promotion Terminology. (2001). Report of the 2000 joint committee on health education and promotion terminology. *American Journal of Health Education*, 32(2), 97-103.
- Joint Committee of Health Education Standards. (1995). *National health education standards: Achieving health literacy*. Atlanta, GA: American Cancer Society.
- Jones, J. (2010). *Americans say jobs top problem now, deficit in future, March 12, 2010*. Retrieved from www.gallop.com.
- Kaiser Family Foundation. (2007). *Kaiser health tracking poll*. Retrieved from http://www.kff.org/kaiserpolls/pomr062007pkg_v2.cfm.
- Kaiser Family Foundation. (2009). *Kaiser health tracking poll*. Retrieved from <http://www.kff.org/kaiserpolls/posr022509pkg.cfm>.
- Kaiser Family Foundation. (2010). *Kaiser health tracking poll, March 2010*. Retrieved from <http://www.kff.org/kaiserpolls/upload/8058-T.pdf>.
- Kaiser Family Foundation. (2009). *National health insurance: A brief history of reform efforts in the U.S.* Retrieved from www.kff.org.
- Kaiser Family Foundation. (2009). *Trends in health care costs and spending*. Menlo Park CA.
- Kaiser Family Foundation, Harvard School of Public Health. (2008, December 4-14). *The public's health care agenda for the new president and congress [poll]*. Retrieved from <http://www.kff.org/kaiserpolls/upload/7853.pdf>.
- Kennedy, E. (1972). *In critical condition: The crisis in America's health care*. New York: Simon and Schuster.

- Kreuger, R. A. (2008). *Focus groups: A practical guide for applied research* (4th ed.). Thousand Oaks, CA: Sage.
- Kull, S., Galston, W., and Ramsay, C. (2009). *Battleground or common ground? American public opinion on health care reform*. Retrieved from www.worldpublicopinion.org.
- Lather, P. and St. Pierre, B. (2006). Paradigm proliferation as a good thing to think with: Teaching qualitative research as a wild profusion. *International Journal of Qualitative Studies in Education*, 19(1), 35-57.
- Levy, R. A. (2011). *The case against President Obama's health care reform: A primer for nonlawyers*. Washington DC: The Cato Institute.
- Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks, CA: Sage.
- Lincoln, Y. S. & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp 163-188). Thousand Oaks, CA: Sage.
- Maves, M. D. (2010). *HHS request for comments regarding exchange-related provisions in Title I of the patient protection and affordable care act (OCIIO-9989-NC)*. Chicago, IL: American Medical Association.
- Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd ed.). Thousand Oaks, CA: Sage.
- McLeroy, K. R., Bibeau, D. L., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15, 351-377.
- Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, California: Jossey-Bass.

- Merriam-Webster, Inc. (2011). [Web site]. Retrieved from <http://www.merriam-webster.com/dictionary/>.
- Miner, K. J. & Baker, J. A. (1993). Health educators as environmental policy advocates. *Journal of Health Education, 24*, 141-144.
- Mitofsky International. (1994). *Mitofsky international poll*. Retrieved from <http://www.mitofskyinternational.com/company.htm>.
- Monegain, B. (2010). U.S. ranks last among seven countries on health care performance. *Healthcare IT News*. Retrieved from <http://www.healthcareitnews.com/news/us-ranks-last-among-seven-countries-healthcare-performance?page=0,0>.
- Morone, J. A. (2010). Presidents and health reform: From Franklin D. Roosevelt to Barack Obama. *Health Affairs, 29*(6), 1096-1100.
- National Center for Health Statistics. (2011). *Health, United States, 2010: With special feature on death and dying*. Hyattsville, Maryland.
- National Center for Policy Analysis. (2011). *Repeal and replace: 10 necessary changes*. Retrieved from <http://www.ncpa.org/pub/repeal-and-replace-10-necessary-changes>.
- National Commission for Health Education Credentialing, Inc. (2011). *Continuing education credit activities*. Retrieved from <http://nchec.org/ce/procal/>.
- National Commission for Health Education Credentialing, Inc. (2000). *Health education code of ethics*. Retrieved from <http://nchec.org/credentialing/ethics/>.
- National Commission for Health Education Credentialing, Inc. (2008). *MCHES overview*. Retrieved from <http://nchec.org/exam/overview/mches/>.

- National Commission for Health Education Credentialing, Inc. (2008). *Responsibilities and competencies of health educators*. Retrieved from <http://nchec.org/credentialing/responsibilities/>.
- Neutens, J. J. & Rubinson, L. (2010). *Research techniques for the health sciences* (4th ed.). San Francisco, CA: Pearson Education, Inc.
- Nichols, B. (2010). *What's meant by A-G requirements?* Retrieved from <http://toped.svefoundation.org/2010/09/01/what-'s-meant-by-a-g-requirements/>.
- Nutbeam, D. (2000). Health literacy as a public health goal: A challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International*, 15(3), 259-267.
- Nyswander, D. (1967). The open society: Its implications for health educators. *Health Education Monograph*, 1, 4-5.
- Obama, B. (2009, February 29). Address to joint session of congress [Video file]. Retrieved from http://www.whitehouse.gov/the_press_office/remarks-of-president-barack-obama-address-to-joint-sessions-of-congress/.
- Office of the National Coordinator for Health Information Technology. (2011). *Improving patient care*. Retrieved from http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204.
- O'Neill, J. E. and O'Neill, D. M. (2007). *Who are the uninsured? An analysis of America's uninsured population, their characteristics and their health*. Washington DC: Employment Policies Institute.
- Ortlipp, M. (2008). Keeping and using reflective journals in the qualitative research process. *The Qualitative report*, 13(4), 695-705.

- Oxford University Press. (2011). *Passion*. Retrieved from
<http://www.oxfordadvancedlearnersdictionary.com/dictionary/passion>.
- PBS. (2010). *Health care crisis: History*. Retrieved from
<http://www.pbs.org/healthcarecrisis/history.htm>.
- Pajares, F. (2007). *Elements of a proposal*. Retrieved from
<http://des.emory.edu/mfp/proposal.html>.
- Parachat. (2011). *Key chat features*. Retrieved from
http://www.parachat.com/documentation/hosted7/Welcome_To_ParaChat.htm.
- Patel, K. (2011). *The President's deficit reduction plan: Implications for health care*.
 Washington DC: The Brookings Institution.
- Patient Protection and Affordable Care Act of 2010, H.R. 3962, 111 d Cong. (2010).
- Peters, B. G. (1999). *American public policy: Promise and performance* (5th ed.). New York:
 Seven Bridges Press, LLC.
- Quadagno, J. (2005). *One nation uninsured: Why the U.S. has no national health insurance*.
 Oxford, New York: Oxford University Press.
- Rasmussen Reports. (2011). *Health care law*. Retrieved from
http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/health_care_law.
- Robert Wood Johnson Foundation, Center to Prevent Childhood Obesity. (2009). *Opportunities to address childhood obesity through health reform*. Retrieved from
http://www.reversechildhoodobesity.org/webfm_send/41.
- Rohwer, J. (1991). Professional advocacy: The Minnesota Epilogue toward altering legislation for quality school health education programs. *Journal of Health Education*, 22, 240-243.

- Schmid, T. L., Pratt, M., & Howze, E. (1995). Policy as intervention: Environmental and policy approaches to the prevention of cardiovascular disease. *American Journal of Public Health, 85*, 1207-1211.
- Schneider, M. & Stokols, D. (2009). Multilevel theories of behavior change: A social ecological framework. In *The handbook of health behavior change* (3rd ed.) (pp 85-105). New York: Springer Publishing Company.
- Schneider, S. J., Kerwin, J., Frechtling, J., & Vivari, B. A. (2002). Characteristics of the discussion in online and face-to-face focus groups. *Social Science Computer Review, 20*(1), 31-42.
- Seeyle, K. Q. (1994, August 16). Lobbyists are the loudest in the health care debate. *New York Times*, A1, A10.
- Shi, L. & Singh, D. A. (2008). *Delivering health care in America: A systems approach* (4th ed.). Sudbury, Massachusetts: Jones and Bartlett Publishers.
- Silag, P. & Conner, K. (2010). *New from EPI: Employer-sponsored health insurance coverage continues to decline sharply*. Washington DC: Economic Policy Institute.
- Starr, P. (2011). *Remedy and reaction: The peculiar American struggle over health care reform*. New Haven: Yale University Press.
- Steckler, A. & Dawson, L. (1982). The role of health education in public policy development. *Health Education Quarterly, 9*, 275-292.
- Stevens, R. A., Rosenberg, C. E., and Burns, L. R. (eds.). (2006). *History and health policy in the United States: Putting the past back in*. Piscataway, NJ: Rutgers University Press.
- Stewart, D. W., Shamdasani, P. N., & Rook, D. W. (2006). *Focus groups: Theory and practice* (2nd ed.). Thousand Oaks, CA: Sage.

- Sukin, D. (2009). Leadership in challenging times: It starts with passion. *Frontiers of health services management*, 26(2), 3-8.
- Susan G. Komen Advocacy Alliance. (2009). *Position paper: Health reform and the Komen Advocacy Alliance*. Retrieved from www.KomenAdvocacy.org.
- TANC. (2009). *A new TANC position paper/research: "Rx for U.S. healthcare reform."* Retrieved from www.transamericanalliance.org.
- Thomas, S. B. (1990). Community and health advocacy for racial and ethnic minorities in the United States: Issues and challenges for health educators. *Health Education Quarterly*, 17(1), 13-19.
- Turnock, B. J. (1997). *Public health: What it is and how it works*. Gaithersburg, Maryland: Aspen Publishers, Inc.
- U. S. Bureau of the Census. (2009). *Statistical abstract of the United States, 2009*. Retrieved from <http://www.census.gov/prod/2008pubs/09statab/health.pdf>.
- U. S. Department of Health and Human Services. (2012). *Funding opportunities*. Retrieved from <https://grants.hrsa.gov/webExternal/fundingOpp.asp>.
- U. S. Department of Health and Human Services. (2010). *Healthy people 2010: Conference edition in 2 volumes*. Washington DC: Government Printing Office.
- U. S. Department of Health and Human Services. (2010). *Initiatives related to the affordable care act*. Retrieved from <http://www.healthcare.gov/law/initiatives/index.html>.
- U. S. Department of Health and Human Services. (N.D.). *Medicare Benefits*. Retrieved from <http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/medicare-benefits-overview.asp>.

- U. S. Department of Health and Human Services. (2011). *Partnership for patients: Better care, lower costs*. Retrieved from <http://www.healthcare.gov/center/programs/partnership/index.html>.
- U.S. Department of Health and Human Services. (2010). *The affordable care act: Overview*. Retrieved from <http://www.healthcare.gov/law/introduction/index.html>.
- U.S. Department of Health and Human Services. (2010). *Understanding the affordable care act: About the law*. Retrieved from <http://www.healthcare.gov/law/about.html>.
- U.S. Department of Health and Human Services. (2011). *Determinants of health*. Retrieved from <http://healthypeople.gov/2020/about/DOHAbout.aspx>.
- U. S. Department of Health and Human Services. (2010). *Provisions of the affordable care act, by year*. Retrieved from <http://www.healthcare.gov/law/about/order/byyear.html>.
- U. S. Department of Health and Human Services. (2010). *Sebelius announces new \$250 million investment to strengthen primary health care workforce*. Retrieved from <http://www.hhs.gov/news/press/2010pres/06/20100616a.html>.
- U.S. Department of Health and Human Services. (2011). *2020 topics and objectives: Access to health services*. Retrieved from <http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1>.
- U.S. Department of Health and Human Services and U.S. Department of Justice. (N.D.). *About fraud*. Retrieved from <http://www.stopmedicarefraud.gov/aboutfraud/index.html>.
- Van Maanen, J. (1979). Reclaiming qualitative methods for organizational research: A preface. *Administrative Science Quarterly*, 24(4), 520-526.
- Washington Post Staff. (2010). *Landmark: The inside story of America's new health-care law and what it means for us all*. New York: Public Affairs.

Weissert, C. S. & Weissert, W. G. (2006). *Governing health: The politics of health policy* (3rd ed.). Baltimore, MD: The John Hopkins University Press.

William, R. A. (ed.). (2011). *Healthcare disparities at the crossroads with healthcare reform* (1st ed.). New York, NY: Springer.

Wyatt, G. E. & Williams, J. K. (2004, July). *Internet chatroom focus groups assessing sexual health issues of MSM workers*. Paper presented at the International Conference on AIDS, Bangkok, Thailand. Abstract no. WePeC6187.

42 U.S.C.A. § 300u-10. (2010).

APPENDICES

APPENDIX A

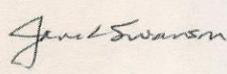
HUMAN SUBJECTS APPROVAL



Southern
Illinois University
Carbondale

Research Development and Administration
Human Subjects Committee
www.siu.edu/orda/human
www.siu.edu

To: Kadi Bliss

From: Jane L. Swanson, Ph.D. 
Chair, Human Subjects Committee

Date: September 8, 2011

Subject: *Health Educators as a Think Tank: Recommendations to Improve Health Care Reform Proposals and Potential roles for the Profession*

Protocol Number: 11355

The revisions to the referenced study have been reviewed and approved by the SIUC Human Subjects Committee.

This approval expires on 8/31/2012, one (1) year from the review date. Regulations make no provision for any grace period extending beyond the above expiration date. Investigators must plan ahead if they anticipate the need to continue their research past this period. The application should be submitted 30 days prior to expiration with sufficient protocol summary and status report details, including number of accrued subjects and whether any withdrew due to complaint or injury. If you should continue your research without an approved extension, you would be in non-compliance of federal regulations. You would risk having your research halted and the loss of any data collected while HSC approval has lapsed. Extensions will not be required to continue work on an approved project when all the data has been collected, there will be no more interaction or intervention with human subjects and **subject identifiers have been removed** (e.g. during the data analysis or report writing stages).

Also note that any future modifications to your protocol must be submitted to the Committee for review and approval prior to their implementation.

Your Form A approval is enclosed. Best wishes for a successful study.

This institution has an Assurance on file with the USDHHS Office of Human Research Protection. The Assurance number is 00005334.

JS:kr

Cc: Roberta Ogletree

SIUC HSC FORM A

REQUEST FOR APPROVAL TO CONDUCT RESEARCH ACTIVITIES
INVOLVING HUMAN SUBJECTS

CERTIFICATION STATEMENT

By making this application, I certify that I have read and understand the University's policies and procedures governing research activities involving human subjects. I agree to comply with the letter and spirit of those policies. I acknowledge my obligation to:

1. Accept responsibility for the research described, including work by students under my direction.
2. Obtain written approval from the Human Subjects Committee of any changes from the originally approved protocol **BEFORE** implementing those changes.
3. Retain signed consent forms in a secure location separate from the data for at least **three** years after the completion of the research.
4. Immediately report any adverse effects of the study on the subjects to the Chairperson of the Human Subjects Committee, SIUC, Carbondale, Illinois - 618-453-4533 and to the Director of the Office of Research Development and Administration, SIUC.
Phone 618-453-4531. E-mail: siuhsc@siu.edu

Project Title

HEALTH EDUCATORS AS A THINK TANK: RECOMMENDATIONS TO IMPROVE HEALTH CARE REFORM

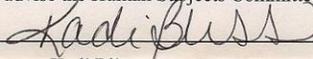
PROPOSALS AND POTENTIAL ROLES FOR THE PROFESSION

RESEARCH ADVISOR'S ASSURANCE: My signature on this application certifies that the student is knowledgeable about the regulations and policies governing research with human subjects. I am aware of my obligations stated on Form A and will be available to supervise the research. When on sabbatical leave or vacation, I will arrange for an alternate faculty sponsor to assume responsibility during my absence. I will advise the Human Subjects Committee by letter of such arrangements.

Researcher(s) or Project Director(s)
Please print or type name below signature.

Kadi Bliss

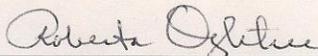
Date



8/31/2011

Researcher's Advisor (required for all student projects) Dr. Roberta Ogletree
Please print or type name below signature.

Date



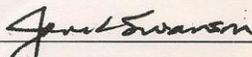
9/21/2011

The request submitted by the above-named researcher(s) was approved by the SIUC Human Subjects Committee.

This approval is valid for one year from the review date. Researchers must request an extension to continue the research after that date. This approval form must be included in all Master's theses/research papers and Doctoral dissertations involving human subjects that are submitted to the Graduate School.

Chairperson, Southern Illinois University Human Subjects Committee

Date



9-8-11

APPENDIX B

REQUEST LETTER TO NCHEC

From: Kadi Bliss, MS, CHES

Subject: Request for CHES/MCHES listserv for dissertation research

Dear NCHEC Board of Directors:

My name is Kadi Bliss, and I am a doctoral candidate at Southern Illinois University Carbondale. I am currently beginning a qualitative dissertation study on the topic of health care reform. I would like to request permission for use of the CHES/ MCHES listserv as the study's population.

The *Patient Protection and Affordable Care Act (PPACA)* was passed March 23, 2010 as an attempt to improve the health care system in America and insure up to 32 million people. Many of the provisions in the *PPACA* promote preventive services that will enable Americans to seek health care before a condition becomes serious, which will save money and improve the health outcomes of Americans. However, there are many stakeholders with opposing vested interests, and these people/groups are fighting against the *PPACA*. As health education specialists, we have a vested interest to promote improved health of Americans through our programs, education, research, and advocacy. Therefore, we serve as a unique think tank for health care reform issues.

The purposes of the study are to explore recommendations from health education specialists for health care reform in relation to the different levels of the determinants of health ecological model and to examine any potential new roles health education specialists may identify as important for the profession in achieving an effective health care system.

A qualitative research design will be used for this study, and health education specialists will be purposefully selected to participate based on criteria of being committed to health care reform. They will be asked to participate in a 45-50 minute online focus group where they will remain anonymous and will be asked to provide recommendations about what needs to be in place in the different levels of the determinants of health ecological model for the health care system to be successful, as well as identifying roles for health education specialists within health care reform.

I believe CHES/MCHES health educators would be the best population for this study because these health education specialists have proven their competency in the profession, they are dispersed throughout the nation, and they have many different professional experiences from which they will likely base their recommendations on.

Please contact my research advisor or me with any questions regarding this research:

Kadi Bliss, MS, CHES
618-453-2777
kgraham@siu.edu

Dr. Roberta Ogletree, HSD, MCHES, FASHA
618-453-1835
bobbie@siu.edu

Thank you for your time and consideration.

Sincerely,

Kadi Bliss, MS, CHES

APPENDIX C

NCHEC LETTER OF APPROVAL



1541 Alta Drive, Suite 303
Whitehall, PA 18052-5642
Toll Free Phone: 888-624-3248
Toll Free Fax: 800-813-0727
Website: www.nchech.org

September 29, 2011

Kadi Bliss
CHES ID 17004
Ph.D. Candidate
Southern Illinois University Carbondale
475 Clocktower Dr.
Pulliam Hall 307, Mail code 4632
Carbondale, IL 62901

Hello Kadi

The Board of Commissioners of the National Commission for Health Education Credentialing (NCHEC) has approved your request for use of our mailing list of CHES for your doctoral dissertation research **Health Educators as a Think Tank: Recommendations to Improve Health Care Reform Proposals and Potential roles for the Profession**

It is our understanding that this dissertation research has been reviewed and approved by the IRB Southern Illinois University. All IRB procedures will be followed.

We have received the \$500 fee via check # 217 on September 26, 2011. A sample of the invitation to participate in the survey must also be submitted prior to the release of the survey. You will also provide NCHEC a copy of the published study after it is completed.

If you have any questions, please contact me at 1-888-623-3248, ext 13. I wish you the very best in your studies.

Sincerely,

Linda Lysoby, MS, CAE, MCHES
Executive Director
The National Commission for Health Education Credentialing, Inc

Cc: Sandy Schaffer, NCHEC
Roberta Ogletree, Research Advisor

APPENDIX D
RECRUITMENT EMAIL

From: Kadi Bliss, MS, CHES

Subject: Do you feel a COMMITMENT to health care reform?

Dear Health Educator:

My name is Kadi Bliss, and I am a doctoral candidate at Southern Illinois University Carbondale. Your name was provided to me by the National Commission for Health Education Credentialing, Inc. (NCHEC) as you are a certified CHES or MCHES health education specialist.

I would like to request your participation in a study I am conducting on health care reform. The purposes of the study are to explore recommendations from health education specialists for health care reform in relation to the different levels of the determinants of health ecological model and to examine any potential new roles health education specialists may identify as important for the profession in achieving an effective health care system.

If you are a health education specialist who feels a commitment to health care reform, you meet the criteria to participate in this study. Participation in the study is strictly voluntary. The Southern Illinois University Human Subjects Committee has reviewed this study.

I am requesting your participation in a 45-50 minute online focus group. You will be given a code name for the focus group so no one can identify you. Only the researcher will have access to the code names. Your participation would be greatly appreciated and a great asset to this study. All information will be kept confidential and you may stop participating in the focus group at any time or refuse to respond to any question.

If you would like to participate in this study, please respond and let me know you are willing to participate and indicate your workplace setting from the following choices: *community, medical, post-secondary, school, worksite, or organization/foundation*. I am also happy to answer any questions you may have about the research being conducted. If you would like to have your name removed from any future mailings, please respond with that request. If you do not respond to this email or return the opt-out message, you will be contacted again with this request up to three times in the next three weeks. Thank you for your time and assistance.

As an incentive for participating in this study, you will be entered into a drawing to receive a bound copy of the entire *Patient Protection and Affordable Care Act*, as well as four recently published books on the topic of health care reform.

Questions about this research can be directed to the researcher or the research advisor:

Kadi Bliss, MS, CHES

Dr. Roberta Ogletree, HSD, MCHES, FASHA

618-453-2777
kgraham@siu.edu

618-453-1835
bobbie@siu.edu

Sincerely,

Kadi Bliss, MS, CHES

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, SIUC, Carbondale, IL 62901-4709. Phone (618) 453-4533. E-mail: siuhsc@siu.edu

APPENDIX E

NOTIFICATION OF SELECTION EMAIL

From: Kadi Bliss, MS, CHES

Subject: Notification of Selection to Participate

Dear Health Educator:

The following research study is being conducted by Kadi Bliss, MS, CHES, a doctoral candidate at Southern Illinois University, Carbondale as part of her doctoral dissertation. The purposes of the study are to explore recommendations from health educators for health care reform in relation to the different levels of the determinants of health ecological model and to examine any potential new roles health educators may identify as important for the profession in achieving an effective health care system.

Criteria for the study require participants to be committed to health care reform. You have indicated that you are committed to health care reform, and have therefore been selected to participate in the study.

Below are two possible dates and times for your focus group to be conducted. Please review your schedule and choose the date and time that is most convenient for you.

_____ (DATE and TIME #1)

_____ (DATE and TIME #2)

Please respond to this email to indicate which date and time you have selected. If you cannot be available during either date or time, please respond with that information.

The first 6-10 health educators that sign up for a particular time and date will be chosen as participants for this round of focus groups. If you select a date and time but are not among the first 6-10 participants to sign up, you will be contacted for the next round of focus groups.

As an incentive for participating in this study, you will be entered into a drawing to receive a bound copy of the entire *Patient Protection and Affordable Care Act*, as well as four recently published books on the topic of health care reform.

If you have any questions about the research being conducted, please contact the researcher or the research advisor:

Kadi Bliss, MS, CHES
618-453-2777
kgraham@siu.edu

Dr. Roberta Ogletree, HSD, MCHES, FASHA
618-453-1835
bobbie@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, SIUC, Carbondale, IL 62901-4709. Phone (618) 453-4533. E-mail: siuhsc@siu.edu

Thank you for participating.

Kadi Bliss, MS, CHES

APPENDIX F

FOCUS GROUP INTERVIEW GUIDE

Topic Areas:

- From a health education perspective, what individual, health service, societal, and policy components should be in place for a successful health care reform plan to succeed?
- What roles in health care reform do participants see as potential roles for health education professionals?
- How do health educators advocate or act on policy issues related to access to health care/ health care reform?

Questions:

- What, if anything, have you been doing to advocate for health or health education.
- Suppose you were on a committee in charge of reforming the health care system. What components would your reform plan include?
 - (Alternative question) Describe what you think the ideal health care system would look like.
- Think of your reform plan. What would individual Americans need in order for your plan to succeed? (knowledge, attitudes, beliefs, skills, etc.)
- What health services would need to be in place? (preventive services, primary care services, etc.)
- What societal/ structural changes would need to occur? (education, environmental changes, social norms, etc.)
- Are there any other policy changes that would need to pass for the reform to succeed?
- (At each level ask:) Would you describe what health educators may be able to do to help make these changes.
- Which recommendations do you think can/should be addressed soon?

Probes:

- What was it like for you when...

- Give me an example of...
- Tell me more about...
- What do you mean by...
- Can you clarify...
- What are your recommendations for access issues, Medicare, Medicaid, prevention services, the individual mandate, financing, providing tax cuts for certain groups, the Exchanges (key areas of the *PPACA*)?

APPENDIX G
CONSENT FORM

From: Kadi Bliss, MS, CHES

Subject: Consent to Participate

Dear Health Educator:

The following research study is being conducted by Kadi Bliss, MS, CHES, a doctoral candidate at Southern Illinois University, Carbondale as part of her doctoral dissertation. The purposes of the study are to explore recommendations from health educators for health care reform in relation to the different levels of the determinants of health ecological model and to examine any potential new roles health educators may identify as important for the profession in achieving an effective health care system.

Criteria for the study require participants to be committed to health care reform. You have indicated that you are committed to health care reform, and have therefore been selected to participate in the study.

Participation is voluntary. Participation in this online focus group indicates voluntary consent to participate in this study. You may refuse to participate without penalty. If you voluntarily choose to participate in the study, it will take approximately 45-50 minutes of your time. If you decide to participate, you may withdraw from the study at anytime without penalty. PARTICIPATION IN THIS ONLINE FOCUS GROUP INDICATES CONSENT TO PARTICIPATE.

I will take all reasonable steps to protect your identity. You will be given a code name so other participants will not have access to any of your identifying information. However, the researcher will be privy to the code names and may contact you to confirm the meanings of focus group responses. No names will be used in the written dissertation. Transcripts from the focus groups will be saved and used for data analysis. All information obtained will be used specifically for research purposes and kept in a locked cabinet that will only be accessible to the researcher and research advisor. The coding will remain active for one year or until all analysis has been completed. Upon completion of the study, all data will be destroyed ensuring confidentiality measures.

Your focus group has been scheduled for _____ (DATE and TIME)_____.

To participate in the focus group, please copy and paste the following web link into your browser at the date and time stated above:

<http://host7.parachat.com/hosted/index.html?site=30755&room=Do-you-feel-a-COMMITMENT-to-health-care-reform&width=600&height=400>

If you have any questions about the research being conducted, please contact the researcher or the research advisor:

Kadi Bliss, MS, CHES
618-453-2777
kgraham@siu.edu

Dr. Roberta Ogletree, HSD, MCHES, FASHA
618-453-1835
bobbie@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, SIUC, Carbondale, IL 62901-4709. Phone (618) 453-4533. E-mail: siuhsc@siu.edu

Thank you for participating.

Kadi Bliss, MS, CHES

APPENDIX H
REMINDER EMAIL

From: Kadi Bliss, MS, CHES

Subject: REMINDER and Log In Information

Dear Health Educator:

Thank you for participating in this dissertation research study! This is a reminder that your focus group has been scheduled for _____ (DATE and TIME)_____.

To participate in the focus group, please copy and paste the following web link into your browser at the date and time stated above:

_____ (WEB LINK)_____.

You will need to enter the following information into the Username and Password field boxes once you have copied and pasted the web link into your browser:

USERNAME: _____

PASSWORD: _____

Below are a few of the questions that will be asked during the focus group. If you have time, please think about your response to these questions before the session as they may require some thoughtful consideration.

- Suppose you were on a committee in charge of reforming the health care system. What components would your reform plan include?
- Think of your reform plan. What would individual Americans need in order for your plan to succeed? (knowledge, attitudes, beliefs, skills, etc.)
- What health services would need to be in place? (preventive services, primary care services, etc.)
- What societal/ structural changes would need to occur? (education, environmental changes, social norms, etc.)
- Are there any other policy changes that would need to pass for the reform to succeed?
- What might health educators be able to do to help make these changes?

Please remember that your participation is voluntary. Participation in this online focus group indicates voluntary consent to participate in this study. You may refuse to participate without penalty. If you voluntarily choose to participate in the study, it will take approximately 45-50 minutes of your time. If you decide to participate, you may withdraw from the study at anytime without penalty. **PARTICIPATION IN THIS ONLINE FOCUS GROUP INDICATES CONSENT TO PARTICIPATE.**

I will take all reasonable steps to protect your identity. You will be given a code name so all responses will be anonymous. However, all focus group participants will be privy to the information shared. No names will be used in the written dissertation. Transcripts from the focus groups will be saved and used for data analysis. All information obtained will be used specifically for research purposes and kept in a locked cabinet that will only be accessible to the researcher and research advisor. The coding will remain active for one year or until all analysis has been completed. Upon completion of the study, all data will be destroyed ensuring confidentiality measures.

If you have any questions about the research being conducted, please contact the researcher or the research advisor:

Kadi Bliss, MS, CHES
618-453-2777
kgraham@siu.edu

Dr. Roberta Ogletree, HSD, MCHES, FASHA
618-453-1835
bobbie@siu.edu

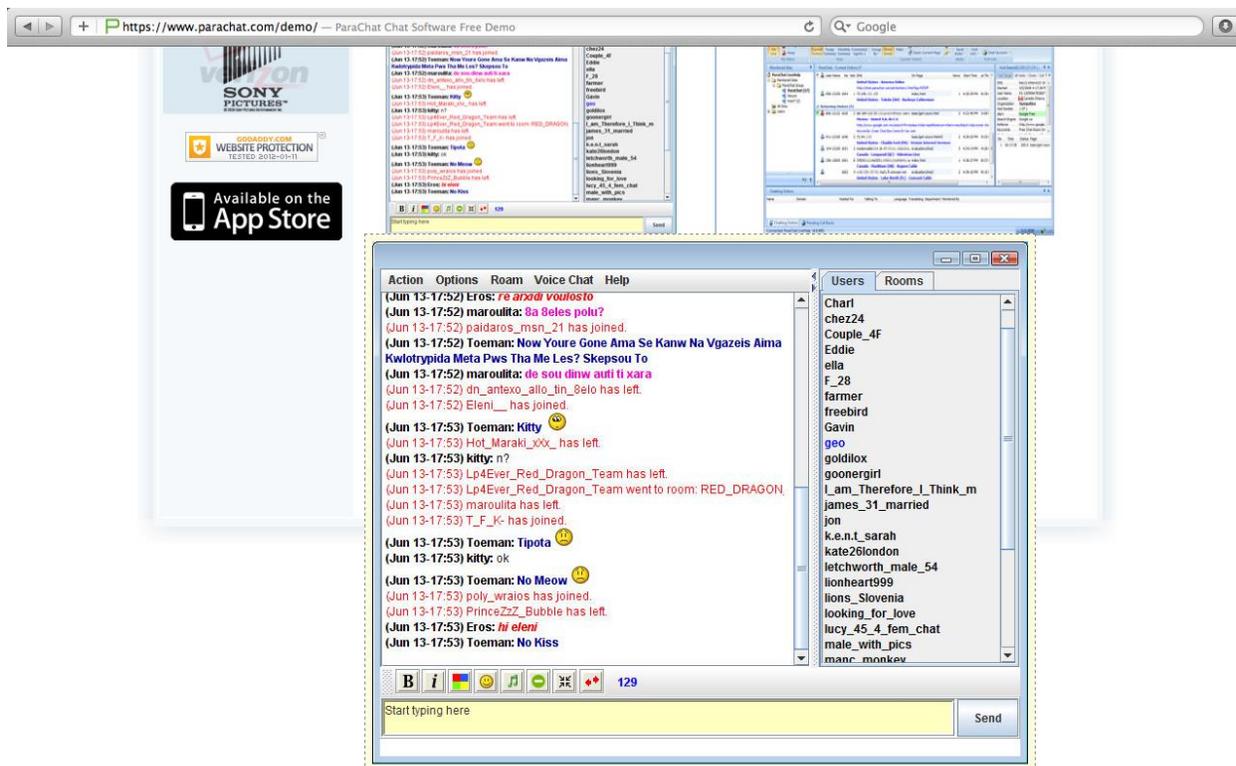
This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, SIUC, Carbondale, IL 62901-4709. Phone (618) 453-4533. E-mail: siuhsc@siu.edu

Thank you for participating.

Kadi Bliss, MS, CHES

APPENDIX I

SCREEN PRINT OF PARACHAT



APPENDIX J
SAMPLE TRANSCRIPT

Nov 2, 2011 12:51:01 PM PDT] [108.199.242.162]		chat-admin joined.
Nov 2, 2011 12:55:04 PM PDT] [209.6.151.66]		Grant joined.
Nov 2, 2011 12:55:51 PM PDT] [209.6.151.66]	Grant	Thank you. I am looking forward to the conversation.
Nov 2, 2011 12:56:15 PM PDT] [108.199.242.162]	chat-admin	Me too!!
Nov 2, 2011 12:56:33 PM PDT] [96.38.230.126]		arthur joined.
Nov 2, 2011 1:00:05 PM PDT] [108.199.242.162]	chat-admin	Welcome and thank you for taking time to participate in this study.
Nov 2, 2011 1:00:08 PM PDT] [207.193.131.101]		Buchanan joined.
Nov 2, 2011 1:00:12 PM PDT] [74.110.215.88]		BHarrison joined.
Nov 2, 2011 1:00:21 PM PDT] [74.110.215.88]	BHarrison	hello!
Nov 2, 2011 1:00:29 PM PDT] [108.199.242.162]	chat-admin	There should be a few more joining us, so we'll give them just a minute or so.
Nov 2, 2011 1:00:36 PM PDT] [108.199.242.162]	chat-admin	Good afternoon.
Nov 2, 2011 1:00:42 PM PDT] [207.193.131.101]	Buchanan	Hi
Nov 2, 2011 1:01:38 PM PDT] [68.181.127.156]		Garfield joined.
Nov 2, 2011 1:02:56	chat-	Are there any questions before we begin?

PM PDT] admin

[108.199.242.162]
Nov 2, 2011 1:03:09 PM PDT] BHarrison I don't have any

[74.110.215.88]
Nov 2, 2011 1:03:17 PM PDT] Garfield Will it be text based or is audio also available?

[68.181.127.156]
Nov 2, 2011 1:03:53 PM PDT] chat-admin Just text based. I thought it would be the easiest for those not familiar with chat rooms.

[108.199.242.162]
Nov 2, 2011 1:03:57 PM PDT] Johnson joined.

[71.71.102.219]
Nov 2, 2011 1:04:38 PM PDT] chat-admin Okay, let's get started. Please feel free to discuss your responses with each other as we proceed.

[108.199.242.162]
Nov 2, 2011 1:05:08 PM PDT] chat-admin My first question for you is what experiences, if any, do you have advocating for health or health education?

[108.199.242.162]
Nov 2, 2011 1:05:46 PM PDT] Buchanan I have lobbied at the local, state, and national level on health care issues over the past 20 years

[207.193.131.101]
Nov 2, 2011 1:06:36 PM PDT] Garfield I teach health education to college students, promote certification through training sessions and offer continuing education. I also promote prevention in my work with health care organizations.

[68.181.127.156]
Nov 2, 2011 1:07:21 PM PDT] arthur I have promoted the importance of vaccination.

[96.38.230.126]
Nov 2, 2011 1:07:29 PM PDT] Johnson In community coalitions and worksite wellness programs - micro level stuff. and yes, in the college setting - I teach sexual health - I am a blogger as well and a you tuber - I personal educate in that manner

[71.71.102.219]
Nov 2, 2011 1:08:01 PM PDT] BHarrison I worked in a sexual health program as well, in prevention

[74.110.215.88]
Nov 2, 2011 1:08:23 PM PDT] chat-admin Great! Now suppose you were on a committee in charge of reforming the health care system. What components would your reform plan include?

[108.199.242.162]
Nov 2, 2011 1:08:59 PM PDT] Grant I teach a course on the U.S. health care system to undergraduates and a health promotion course to graduate physical therapy students. I am working with a physical therapy school in Guatemala to advance their curriculum to change the health of Guatemalans by Guatemalan physical therapists and work within the city where I live with a shelter for women that are homeless to promote their health and physical activity.

[209.6.151.66]
Nov 2, 2011 1:09:24 PM PDT] chat-admin Awesome

PM PDT] admin
 [108.199.242.162]
 Nov 2, 2011 1:10:11 PM PDT] Garfield I would promote several things that are planned already like improving access to insurance for everyone, but also make a big place for prevention to reduce costs
 [68.181.127.156]
 Nov 2, 2011 1:10:25 PM PDT] Johnson OOPS I used johnson to sign in - wow - i need to pay attention - this is Deirdre (aka Johnson)
 [71.71.102.219]
 Nov 2, 2011 1:10:27 PM PDT] Buchanan There would need to be a strong primary and secondary prevention component with incentives for helath care providers to complete benchmarks in this area. There are procedural codes in place now for coding preventive services but many can't get paid for them. Also, health care providers (unfortunately) are the one's people rely on for advice on health. They have to be educated as to what and how to advise on prevention. Right now, there is a general low self-efficacy level for many HC providers
 [207.193.131.101]
 Nov 2, 2011 1:11:07 PM PDT] chat-admin That's okay.
 [108.199.242.162]
 Nov 2, 2011 1:11:24 PM PDT] chat-admin You were supposed to use Johnson....to keep anonymous
 [108.199.242.162]
 Nov 2, 2011 1:11:35 PM PDT] arthur My plan would promote prevention level healthcare, and advocate for access of affordable healthcare to everyone, regardless of pre-existing conditions.
 [96.38.230.126]
 Nov 2, 2011 1:11:38 PM PDT] Garfield Good points, Buchanan!
 [68.181.127.156]
 Nov 2, 2011 1:11:58 PM PDT] Buchanan ::rolleyes
 [207.193.131.101]
 Nov 2, 2011 1:12:01 PM PDT] Johnson I would advocate for prevention and alternatives to over medication - medication studies, medication advertising, medication subscribing and use that money for exercise access - for one thing
 [71.71.102.219]
 Nov 2, 2011 1:12:30 PM PDT] Grant I agree with the points already made. I would also work toward reducing the number of different insurers.
 [209.6.151.66]
 Nov 2, 2011 1:12:48 PM PDT] Garfield Lots of good points. Also important would be making sure everyone has a "medical home" and that health promotion is part of that team of 3 or 4 that comprise each person's medical home.
 [68.181.127.156]
 Nov 2, 2011 1:13:16 PM PDT] Johnson I would also focus on anti smoking measures and food price differentials so that healthy foods were the bargains not the honey buns :)
 [71.71.102.219]
 Nov 2, 2011 1:13:30 PM PDT] Buchanan HP should be required at a "medical home." If they have to have one, they should be able to get advice and resources there

[207.193.131.101]
Nov 2, 2011 1:13:40 PM PDT] Garfield Ideally, we could reduce the number of different insurers to one.
[68.181.127.156]

Nov 2, 2011 1:13:45 PM PDT] BHarrison I think its important to include a hollistic approach as well. To many people turn to to perscriptions when they illness can be treated with other methods
[74.110.215.88]

Nov 2, 2011 1:14:34 PM PDT] Buchanan BHarrison has a point but illness should be prevented where possible with these measures rather than "treated."
[207.193.131.101]

Nov 2, 2011 1:14:57 PM PDT] Johnson YEs to the B's !
[71.71.102.219]

Nov 2, 2011 1:15:14 PM PDT] Grant Changing our reimbursement from procedure based to paying more for preventive counseling and discussion of e.g. plans for weight management etc would help engage patients in managing their own care.
[209.6.151.66]

Nov 2, 2011 1:15:25 PM PDT] chat-admin Thank you! All great ideas :) Now think of your reform plan. What societal/structural changes would need to occur for your plan to be successful?
[108.199.242.162]

Nov 2, 2011 1:15:43 PM PDT] BHarrison thats true, and it would encourage HCPs to do those prevenative measures
[74.110.215.88]

Nov 2, 2011 1:16:11 PM PDT] Johnson Food deserts MUST be addressed and policies to make driving and parking less appealing so more pedestrians and cyclings could emerge
[71.71.102.219]

Nov 2, 2011 1:16:29 PM PDT] Garfield I think trained health educators are going to need to provide a lot of training to HCP's and technical assistance to institutions so they can improve the ways they deliver health promotion
[68.181.127.156]

Nov 2, 2011 1:16:33 PM PDT] Grant Environmental changes such as improved urban parks, walking areas, safety, less reliance on driving to encourage more physical activity.
[209.6.151.66]

Nov 2, 2011 1:16:45 PM PDT] Johnson ditto to Grant
[71.71.102.219]

Nov 2, 2011 1:16:52 PM PDT] BHarrison I think that more 24 hour clinics should be opened to reduce the stress on ERs
[74.110.215.88]

Nov 2, 2011 1:16:54 PM PDT] Buchanan Realistically, the public has to be educated to not be afraid of national health care initiatives. Republican's have made this a dirty word and people fear it although it works in many countires. Education is needed up front. After all, we have a national standard of a 9th grade graduation exam!
[207.193.131.101]

Nov 2, 2011 1:18:10 PM PDT] Johnson I know as a health educator I went to HCPs to educate on smoking cessation and treatment methods - alot of the time Best Practices i.e. asking people if they smoke and advising them to quit - doesn't happen -
[71.71.102.219]

- and if that doesn't happen - preventing obesity is near impossible (at that level)
- Nov 2, 2011 1:18:23 PM PDT] [207.193.131.101] Buchanan It would be nice if dieticians, pharmacists, chiropractors, yoga instructors, naturopaths, and anyone else wanting to do legitimate preventive services could be paid to do them
- Nov 2, 2011 1:18:34 PM PDT] [96.38.230.126] arthur The societal norm of health needs to be changed from a medical ideology to preventive care. Preventing illness rather than treating it later.
- Nov 2, 2011 1:18:52 PM PDT] [68.181.127.156] Garfield If we are not all proactive about health care reform then the lobbyists are the main voices being heard, and they often work against top to bottom reform
- Nov 2, 2011 1:19:00 PM PDT] [71.71.102.219] Johnson Yes - Buchanan that is very true. I had my class go to the website and check out ACA etc. People dismiss it without realizing that things in there are good for THEM
- Nov 2, 2011 1:19:11 PM PDT] [209.6.151.66] Grant We also would need to address whether as a society that we agree that all Americans should have access to health care, regardless of their income or sickness level, i.e. that health care is a right.
- Nov 2, 2011 1:19:45 PM PDT] [207.193.131.101] Buchanan Access to care should be universal in any advanced nation/ society!
- Nov 2, 2011 1:20:04 PM PDT] [74.110.215.88] BHarrison I am a believer of teaching healthy habits young- a stronger health and wellness focus in preschools and elementary schools can make a huge difference in habits later on in life...and this goes beyond having P.E. class, but making sure there are after school sports programs
- Nov 2, 2011 1:20:54 PM PDT] [68.181.127.156] Garfield Interesting point, Grant. We can no longer assume everyone supports health care for all. We need to reframe this as something that affects our nation's health, when whole sectors cannot afford regular care.
- Nov 2, 2011 1:21:26 PM PDT] [108.199.242.162] chat-admin You've mentioned medical homes, prevention services, 24 hour clinics, etc. What other health services would need to be in place for your reform plan to succeed?
- Nov 2, 2011 1:21:46 PM PDT] [207.193.131.101] Buchanan Without a preventive focus, no one will be able to afford healthcare in 5-6 years....
- Nov 2, 2011 1:23:06 PM PDT] [207.193.131.101] Buchanan As to a plan to be successful, you need try insurance reform. In a state I used to live in, BCBS had 95% of the 3rd party reimbursement management. You know how they made thier money? a % of the claim! So the more the care costs, they more they made! No kidding. That has to change.
- Nov 2, 2011 1:23:24 PM PDT] [68.181.127.156] Garfield Good insurance coverage for all. Pharmacy coverage for all... not as options but as requirements. Good health personnel training in medical, nursing and allied health programs to understand population health disparities, challenges and effective strategies to reduce the gaps.
- Nov 2, 2011 1:23:45 PM PDT] [71.71.102.219] Johnson gee - I am not in the health care mind set so much as how to prevent disease or disability from current disease - so Health Services? I don't know what to ask for - other than what has been said. I do want my doc

- (whom I hardly ever see - bc I am well) to know everything s0 EMR and online communication
- Nov 2, 2011 1:24:04 PM PDT [96.38.230.126] arthur There would need to be an emphasis on primary care providers.
- Nov 2, 2011 1:24:25 PM PDT [209.6.151.66] Grant A shift in reimbursement would be needed so that primary care, peditricians, family physicians would be reimbursed more and thus more emerging doctors would be interested in going into those specialities.
- Nov 2, 2011 1:24:49 PM PDT [71.71.102.219] Johnson I know that there are some problems with health insurance competition but it sounds good to me - like when we search for car insurance and agreeing with the others
- Nov 2, 2011 1:24:50 PM PDT [74.110.215.88] BHarrison I think that insurance reform really needs to happen...I can't remember the rate at which its growing but the cost of health care is increasing more than any other sector in the US
- Nov 2, 2011 1:25:00 PM PDT [207.193.131.101] Buchanan Yes Grant. As of today, fewer are going into primary care than ever
- Nov 2, 2011 1:25:27 PM PDT [68.181.127.156] Garfield How about making health promotion part of the medical record in each health care setting.... eg, a small section of each annual visit, interim visit, etc.
- Nov 2, 2011 1:26:27 PM PDT [74.110.215.88] BHarrison I think that when they say that there will be health promtion as a part of the visit the nurse will just be handing the patient a brochure at the end of the visit
- Nov 2, 2011 1:26:35 PM PDT [74.110.215.88] BHarrison which doesn't really help anyone
- Nov 2, 2011 1:27:04 PM PDT [209.6.151.66] Grant Garfield. Good suggestion. Some plans are already doing that and "paying for performance" when PCPs document that they have discussed specific health issues such as weight/smoking.
- Nov 2, 2011 1:27:22 PM PDT [68.181.127.156] Garfield OK, then we may be looking at establishing clearer health educ protocols as well (including health literacy components)
- Nov 2, 2011 1:27:33 PM PDT [207.193.131.101] Buchanan We have to keep in mind, health care providers don't get training in prevention in most cases. They need remediation as to how to advise, when to, and what to do as far as resources. Health Ed could play a huge role there
- Nov 2, 2011 1:27:47 PM PDT [108.199.242.162] chat-admin Now think about individuals. What would individual Americans need for your plan to succeed?
- Nov 2, 2011 1:28:54 PM PDT [207.193.131.101] Buchanan Access to preventive services from trained providers, knowledge of how to navigate the system, electronic records/ medical home, etc, incentives to be well?
- Nov 2, 2011 1:29:06 PM PDT [71.71.102.219] Johnson Access, opporutnity, relevancy, education, promotion, skill - and none of it will work if we don't look at the disparities that exist in all of the things I just mentioned

- Nov 2, 2011 1:29:16 PM PDT] [74.110.215.88] BHarrison they need enough information to understand why prevention is important, but not so much that they feel bogged down
- Nov 2, 2011 1:29:19 PM PDT] [68.181.127.156] Garfield They need an understanding of the importance of insurance, and prevention. Right now the fine under ACA for not having insurance will cost less than paying insurance premiums. For a lot of people they may have to choose that option and may not realize why insurance is so important, until they have to declare bankruptcy for a major medical condition.
- Nov 2, 2011 1:30:23 PM PDT] [209.6.151.66] Grant Good point Buchanan. Both providers and patients need training in prevention. As providers we may need better skills in behavior change and in knowing how to help patients increase their self-efficacy to be able to stay healthy.
- Nov 2, 2011 1:30:48 PM PDT] [96.38.230.126] arthur Individuals would need incentives for preventive/primary care, health literacy, a better understanding of what is included in the ACA
- Nov 2, 2011 1:31:22 PM PDT] [108.199.242.162] chat-admin What types of incentives do you think would be most effective?
- Nov 2, 2011 1:31:22 PM PDT] [74.110.215.88] BHarrison Yes! incentives
- Nov 2, 2011 1:31:27 PM PDT] [207.193.131.101] Buchanan If you ask providers, most of them think someone else is doing the prevention. Primary care gets the assignment but they are not doing it either!
- Nov 2, 2011 1:31:31 PM PDT] [71.71.102.219] Johnson I feel like we are heading to the blame the individual frame - I think we have an obesogenic - disease causing environment and population level measures must be taken - but if you really want only to talk about health care reform - I suppose I can hold back
- Nov 2, 2011 1:32:36 PM PDT] [74.110.215.88] BHarrison well back to car insurance analogies...I see commercials for reduced auto insurance when you go a year without an accident, could you get reduced insurance premiums the same way for health care? or will americans find that as discrimination?
- Nov 2, 2011 1:32:53 PM PDT] [207.193.131.101] Buchanan Johnson makes a good point. By the time a person needs the doc, we are at secondary prevention at best. Treatment does not always = prevention, right?
- Nov 2, 2011 1:33:33 PM PDT] [96.38.230.126] arthur Incentives for providers/insurance co/individuals who focus on prevention/primary care.
- Nov 2, 2011 1:33:49 PM PDT] [207.193.131.101] Buchanan What about an environment conducive to health? The built environment and so on
- Nov 2, 2011 1:34:00 PM PDT] [96.38.230.126] arthur Treatment and prevention are opposites, as medicine and public health are.

Nov 2, 2011 1:34:02 PM PDT] Grant left.
[209.6.151.66]

Nov 2, 2011 1:34:09 PM PDT] Johnson I like the life insurance commercials which actually say that the quotes only apply to nonsmokers - it would be nice to reward people who take care of themselves, but we must also be mindful of persons whose environment makes that damn hard to do
[71.71.102.219] The basic suggestions for prevention sound simple to many of us but I think they are bewildering, about the effects over time of reducing smoking, the effects pro and con of alcohol on heart disease versus cancer, the need for exercise. They are all a package that requires some personal discipline, and a real ramping up of resistance to the advertising and environmental cues. Instead of focusing so much of "do this and that" we need to simplify the healthy steps and encourage people to watch for pressures around them to do unhealthy things. Incentives could be simple recognitions about how much each positive change improves their life quality and life span.

Nov 2, 2011 1:34:18 PM PDT] Garfield
[68.181.127.156]

Nov 2, 2011 1:34:41 PM PDT] Buchanan I think if we rely on providers that make their living treating, we are sunk.
[207.193.131.101]

Nov 2, 2011 1:35:20 PM PDT] chat-admin Now what about policy? Are there other policy changes that could help your plan succeed, or support it?
[108.199.242.162]

Nov 2, 2011 1:35:22 PM PDT] Garfield Insurance incentives, especially in the premiums, would be excellent, and could be justified in terms of savings over time.
[68.181.127.156]

Nov 2, 2011 1:36:21 PM PDT] Garfield We could use policies that restrict unhealthy products in the environment, like banning menthol in cigarettes, reducing subsidies for cheese, etc.
[68.181.127.156]

Nov 2, 2011 1:36:25 PM PDT] Johnson junk food taxes or general sales tax suspension for healthier items
[71.71.102.219]

Nov 2, 2011 1:36:56 PM PDT] Johnson yes Garfield!!
[71.71.102.219]

Nov 2, 2011 1:37:06 PM PDT] Grant joined.
[209.6.151.66]

Nov 2, 2011 1:37:42 PM PDT] Johnson let the NSLP changes take place and adopt the FOP scheme the IOM just released (with some changes) and oh I know, get Walter Willett to run for president :)
[71.71.102.219]

Nov 2, 2011 1:37:43 PM PDT] Garfield This nation needs more "life incentives"... incentives to commodity growers and food manufacturers that support heart healthy products
[68.181.127.156]

Nov 2, 2011 1:37:45 PM PDT] Buchanan Policy changes can drive behavior. Make it a policy that if you don't meet

PM PDT]
[207.193.131.101]

Nov 2, 2011 1:38:17 PM PDT] arthur
[96.38.230.126]

Nov 2, 2011 1:38:31 PM PDT] Johnson
[71.71.102.219]

Nov 2, 2011 1:39:32 PM PDT] Garfield
[68.181.127.156]

Nov 2, 2011 1:39:33 PM PDT] Buchanan
[207.193.131.101]

Nov 2, 2011 1:39:35 PM PDT] Grant
[209.6.151.66]

Nov 2, 2011 1:39:49 PM PDT] chat-admin
[108.199.242.162]

Nov 2, 2011 1:39:58 PM PDT] chat-admin
[108.199.242.162]

Nov 2, 2011 1:40:52 PM PDT] Garfield
[68.181.127.156]

Nov 2, 2011 1:41:09 PM PDT] Buchanan
[207.193.131.101]

Nov 2, 2011 1:41:13 PM PDT] Johnson
[71.71.102.219]

Nov 2, 2011 1:41:26 PM PDT] Grant
[209.6.151.66]

Nov 2, 2011 1:42:13 PM PDT] Garfield
[68.181.127.156]

Nov 2, 2011 1:42:42 PM PDT] chat-admin
[108.199.242.162]

some bench marks, providers get paid less, insured get to pay more. Have policies in place that support patients who want a preventive plan or who make healthy choices. TAX all tobacco products out of existence. Reward cities for more parks, tracks, bike paths-maybe we do, not sure
Policy regarding access to healthcare/insurance is a must, but not so far as to mandate. Taxes on unhealthy foods/items and reduced or abolished taxes on healthy foods/items.

cigarettes suck - but I am not convinced that nicotine does -

Use the tobacco taxes for bike paths

Last time I looked, nicotine was thought to strip the intimal layer of the artery making plaque more likely to stick. Has that changed? Maybe it has, not sure about that

I agree that policies can drive and encourage change. Taxing unhealthy behaviors such as smoking has worked.

Thank you! Out of all the recommendations you've made thus far, are there specific one you think can/should be addressed soon?

Any priorities?

Willet for president! And insurance coverage for everyone, including recent immigrants and people who cannot navigate complex insurance choice systems

In our current situation, rewarding primary care for prevention benchmarks would get the ball rolling and maybe get more involved in preventive care but allowing all providers of health and wellness to be paid for services related would be a good start

yes - supporting the menu and vending labeling initiatives in the ACA and the promo and edu that should accompany them

Working toward decreasing the 45 or so million of Americans that are under-insured or uninsured.

I agree that institutional changes to support prevention and health promotion are a high priority. That may include training, chart and medical home changes, and incentives for health promotion delivery and individual changes.

And what can health educators do to help make some of these changes?

Nov 2, 2011 1:43:16 PM PDT] BHarrison advocate, work together and talk to local representatives
[74.110.215.88]

Nov 2, 2011 1:43:23 PM PDT] arthur Educate the public on the importance of these issues
[96.38.230.126]

Nov 2, 2011 1:43:48 PM PDT] Garfield Those of us at universities need to be preparing our health education graduates to be proactive about health promotion at the institutional, governmental and individual level and offer them the training and policy formation/enactment/compliance promoting tools to get things moving.
[68.181.127.156]

Nov 2, 2011 1:43:50 PM PDT] Grant Educate students to become advocates for these changes.
[209.6.151.66]

Nov 2, 2011 1:43:53 PM PDT] Buchanan HE can train provider groups on how to deliver prevention advice, can train the public on good choices, navigation of the complex healthcare system, kids and academic institutions on policy driven interventions, etc, advocate, lobby
[207.193.131.101]

Nov 2, 2011 1:44:37 PM PDT] Johnson live what they say out to be happening
[71.71.102.219]

Nov 2, 2011 1:45:31 PM PDT] Garfield I agree with the need to train providers.
[68.181.127.156]

Nov 2, 2011 1:45:39 PM PDT] chat-admin Thank you all for participating! That's all of my questions. If you could indicate your years of experience in the health education field before signing off, that would be great.
[108.199.242.162]

Nov 2, 2011 1:45:54 PM PDT] chat-admin Have a good evening!
[108.199.242.162]

Nov 2, 2011 1:46:02 PM PDT] BHarrison thank you for having us
[74.110.215.88]

Nov 2, 2011 1:46:12 PM PDT] Buchanan H. Ed, 11 years. (health care 20+)
[207.193.131.101]

Nov 2, 2011 1:46:13 PM PDT] chat-admin No, thank you!!!
[108.199.242.162]

Nov 2, 2011 1:46:18 PM PDT] BHarrison 3 years
[74.110.215.88]

Nov 2, 2011 1:46:31 PM PDT] Grant 25 years
[209.6.151.66]

Nov 2, 2011 1:46:36 PM PDT] Garfield 30 years in health education. And a lot more years ahead.

PM PDT] [68.181.127.156] Nov 2, 2011 1:46:45	chat- admin)
PM PDT] [108.199.242.162] Nov 2, 2011 1:46:57		BHarrison left.
PM PDT] [74.110.215.88] Nov 2, 2011 1:46:58	arthur	1 year, working on my MPH
PM PDT] [96.38.230.126] Nov 2, 2011 1:47:03		Buchanan left.
PM PDT] [207.193.131.101] Nov 2, 2011 1:47:05		Grant left.
PM PDT] [209.6.151.66] Nov 2, 2011 1:47:09	chat- admin	Great!
PM PDT] [108.199.242.162] Nov 2, 2011 1:47:17		Garfield left.
PM PDT] [68.181.127.156] Nov 2, 2011 1:47:31	Johnson	oh sorry - about ten
PM PDT] [71.71.102.219] Nov 2, 2011 1:47:36		Johnson left.
PM PDT] [71.71.102.219] Nov 2, 2011 1:47:36		arthur left.
PM PDT] [96.38.230.126] Nov 2, 2011 1:53:14		chat-admin left.
PM PDT] [108.199.242.162]		

APPENDIX K

MEMBER CHECKING EMAIL

From: Kadi Bliss, MS, CHES

Subject: Notification for Review of Transcript

Dear Health Educator:

Thank you for participating in this dissertation research study!

I have coded and analyzed your responses from the focus group session, and have attached them for your review. If you wish, please look over your responses as well as my notes to ensure that all information is correct according to your recollection. If you have any modifications, additions, or questions regarding your recorded responses or my notes, please respond to this email by (DATE, one week from sending email) .

If you have any questions about the research being conducted, please contact the researcher or the research advisor:

Kadi Bliss, MS, CHES
618-453-2777
kgraham@siu.edu

Dr. Roberta Ogletree, HSD, MCHES, FASHA
618-453-1835
bobbie@siu.edu

This project has been reviewed and approved by the SIUC Human Subjects Committee. Questions concerning your rights as a participant in this research may be addressed to the Committee Chairperson, Office of Research Development and Administration, SIUC, Carbondale, IL 62901-4709. Phone (618) 453-4533. E-mail: siuhsc@siu.edu

Thank you for participating.

Kadi Bliss, MS, CHES

APPENDIX L

PARTICIPANT DEMOGRAPHICS/ CHARACTERISTICS OF INTEREST

Workplace Setting	Gender	Years of Experience	Code Name
Community	Male	7	Van Buren
Community	Female	11	Monroe
Community	Female	8	Jackson
Community	Female	17	Kennedy
Community	Female	5	Gerry
Community	Male	41	LBJohnson
Community	Female	27	Ford
Community	Female	15	Harding
Community	Female	6	Cleveland
Community	Female	6	Hoover
Community	Male	37	Hayes
Community	Female	40	Clinton
Community	Female	8	Truman
Community	Female	20	Rockefeller
Medical	Male	20	Taft
Medical	Female	12	Roosevelt
Medical	Female	20	Marshall
Medical	Male	30	Fairbanks
Medical	Female	6	Bush
Medical	Female	9	McKinley
Organization/Foundation	Female	15	Hobart
Organization/Foundation	Male	25	Adams
Organization/Foundation	Female	34	Dawes
Organization/Foundation	Female	9	Curtis
Post-Secondary	Female	25	Grant
Post-Secondary	Female	1	Arthur
Post-Secondary	Male	20	Buchanan
Post-Secondary	Female	3	BHarrison
Post-Secondary	Female	30	Garfield
Post-Secondary	Female	10	Johnson
Post-Secondary	Female	4	Wheeler
Post-Secondary	Male	18	Hendricks
Post-Secondary	Female	23	Colifax
Post-Secondary	Male	38	King
Post-Secondary	Female	30	Butler
Post-Secondary	Female	2	Barkley
Post-Secondary	Female	16	Hamlin
Post-Secondary	Female	32	Dallas

Post-Secondary	Male	9	Pierce
Post-Secondary	Female	9	Mondale
Post-Secondary	Male	8	Washington
Post-Secondary	Female	6	FDRoosevelt
Post-Secondary	Male	30	Fillmore
School	Female	19	Wilson
School	Female	13	Wallace
Worksite	Female	12	Polk
Worksite	Male	6	Tyler
Worksite	Female	8	Harrison
Worksite	Female	36	Morton

APPENDIX M

DESCRIPTION OF PARTICIPANTS IN EACH FOCUS GROUP/ INTERVIEW

Focus Group 1- Conducted 11/1/2011 (n=3)

Workplace Setting	Gender	Years of Experience
Community	Male	7
Community	Female	11
Community	Female	8

Focus Group 2- Conducted 11/2/2011 (n=4)

Workplace Setting	Gender	Years of Experience
Worksite	Female	12
Worksite	Male	6
Worksite	Female	8
Worksite	Female	36

Focus Group 3- Conducted 11/2/2011 (n=6)

Workplace Setting	Gender	Years of Experience
Post-Secondary	Female	25
Post-Secondary	Female	1
Post-Secondary	Male	20
Post-Secondary	Female	3
Post-Secondary	Female	30
Post-Secondary	Female	10

Interview 1- Conducted 11/3/2011 (n=1)

Workplace Setting	Gender	Years of Experience
Medical	Male	20

Interview 2- Conducted 11/5/2011 (n=1)

Workplace Setting	Gender	Years of Experience
School	Female	19

Focus Group 4- Conducted 11/14/2011 (n=4)

Workplace Setting	Gender	Years of Experience
Community	Female	17
Community	Female	5
Community	Male	41
Community	Female	27

Focus Group 5- Conducted 11/15/2011 (n=6)

Workplace Setting	Gender	Years of Experience
Post-Secondary	Female	4
Post-Secondary	Male	18
Post-Secondary	Male	20
Post-Secondary	Female	23
Post-Secondary	Male	38
Post-Secondary	Female	30

Focus Group 6- Conducted 11/15/2011 (n=3)

Workplace Setting	Gender	Years of Experience
Medical	Female	12
Organization/Foundation	Female	15
School	Female	13

Focus Group 7- Conducted 11/16/2011 (n=2)

Workplace Setting	Gender	Years of Experience
Medical	Female	20
Medical	Male	30

Focus Group 8- Conducted 11/16/2011 (n=3)

Workplace Setting	Gender	Years of Experience
Organization/Foundation	Male	25
Organization/Foundation	Female	34
Organization/Foundation	Female	9

Focus Group 9- Conducted 11/29/2011 (n=2)

Workplace Setting	Gender	Years of Experience
Community	Female	15
Post-Secondary	Female	2

Focus Group 10- Conducted 11/29/2011 (n=2)

Workplace Setting	Gender	Years of Experience
Medical	Female	6
Medical	Female	9

Focus Group 11- Conducted 11/30/2011 (n=6)

Workplace Setting	Gender	Years of Experience
Community	Female	6
Community	Female	6
Community	Male	37
Community	Female	40
Post-Secondary	Female	16
Post-Secondary	Female	32

Focus Group 12- Conducted 12/1/2011 (n=7)

Workplace Setting	Gender	Years of Experience
Community	Female	8
Community	Female	20
Post-Secondary	Male	9
Post-Secondary	Female	9
Post-Secondary	Male	8
Post-Secondary	Female	6
Post-Secondary	Male	30

APPENDIX N

CATEGORY, RECOMMENDATION AREA, & RECOMENDATION TABLE

Category	Recommendation Area	Recommendation
Individual	Knowledge	About prevention
		About health services available
		About health care reform policies
		About existing health disparities
Individual	Attitude	About limitations of health care
		That is not too overwhelming
		Personal responsibility
		Empowerment
Individual	Skills	Patience (for non-emergency care)
		Proactive
		Goal-setting
		With incentives for increasing
Individual	Health literacy	With assistance (personal health navigator, care lines)
		For those practicing prevention (including health educators*)
		For mental health care*
		More primary care providers trained to deliver prevention and address health disparities*
Health Services	Insurance coverage	Electronic medical records
		Medical home model
		1-stop health care shopping
		Between school and family health services
Health Services	Care coordination	Online communication with primary care provider
		Programs
		Chronic disease self-management
		Peer led programs
Health Services	Prevention	Well-care check-ups
		Education at all doctors' visits
		Increased immunizations

		Consistently provided Incentives for prevention activities*
	End-of-life care	Increased use of home health care Decision-making earlier
Societal	Healthy environment*	Walk/ bike trails Farmer's markets Address food deserts Urban parks Active transit Incentives for increasing
	Social norms	Healthy environment accepted Health care is a right (not a privilege) Prevention is the norm (not treatment) Physical activity versus exercise Health care is a bipartisan effort Address health at multiple levels
	Media/social marketing	Unified message ("Health Wellness for All") Increased utilization of social marketing Promote healthy foods Decrease use of false advertisement
	Education	Free More health education (younger) Coordinated School Health Programs
	Address root causes	Health disparities Target groups most in need Cultural competency
Policy	Taxes	Alcohol, tobacco, low-nutrient foods, soft drinks, candy Pharmaceutical companies Eliminate taxes on healthy foods
	Health insurance issues	Universal* Quality* Comprehensive Focus on prevention High deductible health plans

		<ul style="list-style-type: none"> Target groups most in need Decrease gaps in coverage* Better qualifying policies More regulations on insurance companies
	Specific policies	<ul style="list-style-type: none"> Ban prescription drug advertisements Ban new fast food restaurants Mandate P.E. in school, everyday Implement color-coded food labels Fund state demonstration projects for health care reform proposals Improve Medicaid & Medicare (don't underfund) Include health literacy in health care reform proposals Issue less reimbursement for health care providers who do not meet health benchmarks for patients
	Policy makers	<ul style="list-style-type: none"> Decrease lobbyist power Educate policy makers (use blogs) Increase transparency in campaigning (to promote health)
Role of Health Educator	In medical setting	<ul style="list-style-type: none"> Health education in the primary care setting (the other 45 minutes) Educate public on medical system (ex. When to use the E.D.) Increase health literacy of patients Educate health care providers on EMR Help patients navigate the health care system Be a part of the medical home team
	In political setting*	<ul style="list-style-type: none"> Understand health care reform issues Cost-benefit analysis of <i>PPACA</i> Advocate (for prevention, health care reform) Collaborate with organizations (AMA, CDC, NCHEC, etc.) National coalition to promote health care reform* Become politicians

	<p>Work in legislative departments</p> <p>Develop health care reform model based on other countries*</p> <p>Focus on early adopters</p> <p>Will increase credibility and recognition of profession</p>
Education	<p>Create social marketing campaign to educate public (fun, up-to-date)</p> <p>Train health education students to advocate and become politically involved</p> <p>Expand prevention programs</p> <p>Educate about misperceptions of <i>PPACA</i></p>

Note. * represents a priority theme or subtheme