

From: Hugh Blumenfeld [REDACTED]
Sent: Tuesday, November 26, 2013 4:37 AM
To: SIM, OHA
Subject: Comments on the SIM

To Whom It May Concern

Re: SIM Draft

My name is Hugh Blumenfeld, and I am a Family Physician.

I am also a faculty member at the University of Connecticut School of Medicine where, in addition to teaching medical students and residents in core curriculum areas, I also serve as a faculty member for the UST program. In addition to my medical credentials, I have a PhD in English Literature, with training in composition and rhetoric; therefore, language interests me, specifically the role of language in shaping perception and motivating action.

There are 4 areas that interest me most in promoting health in CT:

1) Food quality and security. As a primary care physician, I am all too aware of the fact that my patients generally make poor food choices. However the problem has 4 parts:

a) we live in an extremely toxic food environment. This affects poor and underserved communities the hardest, but the obesity epidemic touches everyone to some extent. Many ingestible products are marketed as food in a cynical and shameful way by manufacturers and marketers. It is time to stop this mass marketing of toxic substances. The laws against trans-fats are a start. Down the line should be limiting high-fructose corn syrup and other sweeteners, artificial sweeteners (which as far as I know have not been shown to improve health or decrease weight), occult MSG, and added salt.

b) many people lack food security - good nutritious foods are expensive, while toxic, largely processed food-materials are cheap and indirectly subsidized. This needs to be reversed, and taxing low quality foods while providing discounts on high quality foods is an essential part of the SIM.

c) "food deserts": many people in Hartford, and I imagine other large CT cities, do not have easy access to the large supermarkets where food prices are cheaper and the selection is greater. Due to the combination of a lack of big box markets and poor public transportation, many city-dwellers are forced to buy most of their groceries at local markets where prices are high and both quality and selection is poor. I believe a health plan needs to include incentives for retail food chains to locate stores and an effective public transportation system to allow people to shop there. The best solution would be permanent large farmer's markets like those in Atlanta/Decatur.

d) demystification of the link between food and disease. The medical profession has to be more candid about the problem, and stop promoting diabetes medications and bariatric surgery as the solution to a nation of people who consume too much of various food-like substances that are killing them. Diabetes has to be called what it is: Sugar Poisoning. And obesity itself needs to be reconsidered: it is not a disorder, it is the result of a disorder. It is a result of a combination of overeating and food poisoning. I do not believe these terms are too strong. Anorexia has long been recognized as an eating disorder, but though overeating and food poisoning exist as diagnoses, they are not often used. Also, certain consumable products like soft drinks should not be considered to be food, as they have no nutritional value. Perhaps they should be sold in package stores instead of supermarkets. Changing America's eating habits will require reclassifying diseases and recategorizing food-products. "Cheese-food products," "juice drinks" and other misleadingly labeled items need to be separated from the real foods that people would benefit more from.

2) Community Health Workers

It is essential that the medical world partner with communities and neighborhoods and bring the promotion of health, wellness and disease prevention out of the realm of the clinic/office. By the same token, self-care of chronic illness can probably also be better managed out in the community, with peer support and education.

3) UST/CST

UST currently champions a model in which interdisciplinary care teams get out into the community, partner with community organizations, and connect people in need to health care services. It's a great model for making the health care system more efficient and effective. At the present time, these activities are largely ad hoc and disconnected from the larger health care system, however with the development of HIT and HIE, these service activities could be offered within the context of continuity of care and chronic disease management.

4) Patient Education / Health Literacy

The information we give to patients is unnecessarily complex (as in diabetes is caused by hyperglycemia due to insulin resistance) and far too dependent on numerical literacy (average blood sugars, blood pressures, cholesterol levels), when the real messages are simple and could easily be made clear, both verbally and graphically. Developing a new language with which to discuss disease, as well as clearer labeling of foods and medical products, would go a long way toward helping patients participate in their own care effectively and knowledgeably.

Thank you for taking the time to consider these comments on the SIM document/plan.

Sincerely,

Hugh Blumenfeld, MD PhD

University of Connecticut School of Medicine Department of Family Medicine