



HEALTH EDUCATOR JOB ANALYSIS - 2010

A Cooperative Project of the American Association for Health Education, National Commission for Health Education Credentialing, and Society for Public Health Education

Executive Summary and Recommendations

The Health Educator Job Analysis (HEJA) was a multi-phased national study commissioned by the American Association for Health Education (AAHE), Society for Public Health Education (SOPHE), and the National Commission for Health Education Credentialing, Inc (NCHEC) in 2008 and conducted by the Professional Examination Service (PES). The study describes the contemporary practice of health educators in the United States. It represents the culmination of nearly two years of planning, execution, data analyses, and writing. The study purposes were to: 1) validate the contemporary practice of entry- and advanced-level health educators, 2) provide guidance for the development of the Certified Health Education Specialist (CHES) and Master Certified Health Education Specialist (MCHES) examinations, 3) report on changes in health education practice since the last major job analysis study completed in 2005, and 4) inform professional preparation and continuing education initiatives.

HEJA Participants

The HEJA research, under the direction of PES, was guided by two groups of health education professionals: the Health Education Job Analysis Steering Committee (HEJA-SC) and the Health Education Job Analysis Task Force (HEJA-TF). The HEJA-SC consisted of the chief staff officers from each sponsoring organization, the 2008 coordinator of the NCHEC Division Board for Certification of Health Education Specialists, and the appointed HEJA-TF chair. The 11 HEJA-TF members were selected from a pool of more than 200 volunteer nominees generated through a *call to the profession*. An additional 48 volunteers selected from this pool served in the *instrument development* phase of the study as subject-matter experts (n=9), independent reviewers (n=18), and survey pilot participants (n=21). These 59 volunteers were selected to ensure representation of the diversity of health education work settings, educational backgrounds, and experience levels of the profession; and to maintain demographic and geographic diversity.

In the *survey implementation* phase of the study, a primary goal in the sampling process was to achieve representation among survey participants from all work settings and variation in education levels, years of experience, and CHES status. Because no single source exists through which all practicing health educators can be accessed, multiple approaches were used to develop the sample of health educators invited to complete the survey. Member organizations of the Coalition of National Health Education Organization (CNHEO) helped publicize the study to their members via electronic communication channels and conferences. These communications included directions to an online site where volunteers could sign up to participate and provide their email address to which a survey link could be sent.

Nine hundred eighteen volunteers (918) responded to invitations disseminated through CNHEO members. In addition, a stratification technique was used to draw a sample of 4,208

Certified Health Education Specialists (CHES) from the NCHEC database that represented all work settings and varying years of experience. An invitation to complete the online survey was emailed to this total de-duped sample of 5,126 health educators. Of the 5,126 email addresses used, 269 were invalid. Another 108 individuals on this list were removed from the database based on an initial screening to include only practicing health educators as participants. Of the resulting 4749 practicing health educators sampled, 1022 completed the survey for a response rate of 21.5%. Responding health educators were distributed across every state in the United States and the District of Columbia and a wide array of work settings (e.g., community, school, college/university, health care, business/industry).

Study Procedures

The 18-month HEJA study (June 2008 to November 2009) entailed the process of selecting volunteers previously described, followed by two general phases of instrument development and survey implementation. In the instrument development phase, a combination of structured interviews, focus groups, and modified Delphi techniques was used to systematically update the model of health education practice and to create and validate a survey instrument. The validated survey was implemented for data collection and the results were analyzed and interpreted. The entire 18-month study process consisted of the following steps.

- Selection of the HEJA-TF and other volunteer health educators to contribute to instrument development (June-July 2008)
- Preliminary telephone interviews with 9 subject matter experts (August 2008)
- Preliminary work by the HEJA 2010-TF to update the description of health education practice through a face-to-face meeting and follow-up activities (September-October 2008)
- Follow-up work of a *terminology committee* (3 HEJA 2010-TF members) to review the draft survey for consistency of terms (November 2008)
- A Web-based HEJA 2010-TF review of and comment on the reconciled draft survey.
- Follow-up work of a *content reconciliation committee* (2 HEJA 2010-TF members and 1 steering committee member) to reconcile feedback from individual HEJA 2010-TF members (December 2008)
- An independent review process with 18 independent reviewers representing diverse work settings (December 2008-January 2009)
- A face-to-face meeting of the HEJA 2010-TF to review and reconcile the independent review results, create a pre-survey iteration of the model, and develop survey rating scales (January 2009)
- Development of a stratified random sampling plan for the validation survey by PES, and outreach to the profession for volunteer survey participants by HEJA 2010-SC and HEJA 2010-TF members (January 2009)
- Institutional Review Board approval of the study by Baylor University (February 2009)
- Pilot testing of the online survey instrument for comprehensiveness, clarity, and technical ease of use (February 2009)
- HEJA 2010-TF subcommittee review and reconciliation based upon pilot test findings (March 2009)

- Email invitation to participate in the study sent to a sample of 4,749 health educators. Periodic reminders sent throughout 6-week completion window resulting in 21.5% response rate (April-May 2009)
- HEJA 2010-TF review of survey results in a face-to-face meeting and development of recommendations to the HEJA 2010-SC (June 2009)
- HEJA 2010-SC review of task force recommendations and finalization of the model (July – November 2009)

Survey Instrument

The validated instrument used in this analysis included 246 sub-competencies framed within eight areas (evaluation and research sub-competencies were formatted within separate areas for testing purposes). The 4-point rating scales used in the Competencies Update Project (CUP) completed in 2005 were used in this instrument so that participants could rate each sub-competency in terms of:

- Frequency of practice within the past 12 months: *Not at all, occasionally (less than once a month), frequently (at least once each month, very frequently (at least once each week)*
- Importance of the sub-competency to the participant's work: *Not important, minimally important, moderately important, highly important*

The instrument also contained 115 knowledge items. A 4-point rating scale based on the Revised Bloom's Taxonomy was used by participants to rate these items in terms of cognitive levels of use in their work (*I do not use the knowledge, I recognize and/or recall the knowledge, I apply and/or integrate the knowledge, I use the knowledge to evaluate and/or create*). Demographic and professional questions were included to gather information about participant education, experience levels, work setting, type of work performed, professional credentials, organizational memberships, and race/ethnicity.

As previously indicated, the online survey was tested and validated through a survey pilot. Based on pilot feedback, the online survey system was adjusted to allow participants to exit and return to the system as needed over time to complete the full survey. Upon entry into the online survey system, participants were directed to read a study overview and indicate *informed consent* (approved by an institutional review board) prior to completing the one-hour survey.

Analysis and Outcomes

PES experts compiled survey responses into formats and guided the HEJA-TF in data analysis and interpretation. Prior to data analysis, a composite score [(Frequency – 1) + Importance] was created for analyzing sub-competency ratings, as was used in the CUP model. The HEJA 2010-TF decided to exclude items receiving a composite score of less than 3.0 as representing a sub-competency considered unimportant or performed infrequently. All 246 sub-competencies included in the survey met the 3.0 composite score criterion and could be included in the model. However, other results also indicated that the research and evaluation areas should be combined. A resulting 223 sub-competencies were included in the HEJA 2010 model.

The interpretation of knowledge item ratings was based on the percentage of respondents indicating use of that knowledge in their practice. Knowledge items used by at least 50% of respondents were included in the model. Of the 115 knowledge survey items, 113 met the inclusion criterion.

A model of the practice of health education was updated, refined and validated through the HEJA process. The *HEJA 2010* model consists of 223 sub-competencies organized into 39 competencies within the following seven major areas of responsibility.

- I. Assess needs, assets, and capacity for health education
- II. Plan health education
- III. Implement health education
- IV. Conduct evaluation and research related to health education
- V. Administer and manage health education
- VI. Serve as a health education resource person
- VII. Communicate and advocate for health and health education

The three distinct levels of practice established through the CUP study were verified in this HEJA study. These three levels were identified as *entry* (less than five years of experience and a baccalaureate or master degree), *advance 1* (five or more years of experience and a baccalaureate or master degree), and *advance 2* (five or more years of experience and a doctoral degree). Consistent with CUP findings, these practice levels represent a hierarchical model in which the two advanced levels include sub-competencies used at entry levels, along with additional advanced-only sub-competencies. Of the 223 sub-competencies identified in the study, 61 were validated as advanced-level only. Distinctions between the two advanced levels will be addressed in follow-up reports.

The HEJA outcomes reaffirmed seven major areas of responsibility for health education specialists. New and/or expanded competencies were identified in areas related to ethics, partnership development, training, consultative relationships, influencing policy, and promoting the health education profession. One hundred thirteen (113) knowledge items relevant to health education practice were also developed and empirically validated for the first time. Example knowledge areas include theory, community organization, professional ethics, advocacy, and policy development.

Implications and Recommendations

Interpretation of HEJA outcomes should be considered within the context of study limitations. The survey items were designed to measure the degree to which each sub-competency was used by the participant during the past 12 months of work and was considered important in the participant's work. Responses cannot serve as an indicator of performance quality, professional preparation related to specific skills, nor perceptions of what the participant thinks she or he should be doing in the future. The knowledge items on the survey were designed to measure cognitive levels of use but did not measure specific application methods or contexts.

As in previous research, lack of any one comprehensive database of health education specialists made identifying health education specialists in all practice settings a challenge. Future research will need to continue to address this issue. Use of an online format and 6-week window for survey completion was based on industry standards and recommendations for periodic updates (every 5-7 years). The 21.5% response rate in this study is comparable to that obtained in other job analyses conducted by PES, and is in line with the range of response rates generally found in professional job analyses. Given that the average amount of time required to

complete the survey was close to one hour, these responses reflect the opinions of a cohort of thoughtful and committed health educators.

The HEJA 2010 outcomes have significant implications for professional certification, preparation, continuing education, and practice in the health education profession. The board of directors of SOPHE, AAHE, and NCHEC reviewed the study report and developed six recommendations for the profession.

1. Baccalaureate programs in health education should prepare health education graduates to perform all 7 of the health education responsibilities, 34 competencies and 162 sub-competencies identified as Entry-level in the 2010 hierarchical model.
2. NCHEC should use all 7 health education responsibilities, 34 competencies and 162 sub-competencies identified as Entry-level in the 2010 hierarchical model as the basis for revisions to the entry-level Certified Health Education Specialist examination.
3. Graduate programs in health education should ensure the preparation of health education graduates to perform all 7 of the health education responsibilities, 34 competencies and 223 sub-competencies (162 Entry-level and 61 Advanced-level) in the 2010 hierarchical model
4. NCHEC should use the advanced level responsibilities, competencies and sub-competencies for the new advanced level exam.
5. All of the responsibilities, competencies and sub-competences should be used for professional development activities
6. Accrediting and approval bodies should be encouraged to recognize the 2010 Health Education Job Analysis responsibilities, competencies and sub-competencies as the basis for quality assurance for professional preparation programs.

Profession-wide support of these six recommendations can significantly impact the future of the health education profession. For example, the HEJA 2010 model is already in use by NCHEC leaders to develop specifications for the pending Master Certified Health Education Specialist (MCHES) examination. The model can also be useful in current efforts to develop a unified or coordinated approach to accreditation for professional preparation programs. Professional development and continuing education can be expanded to include appropriate levels of learning for those in advanced levels of practice. As with the CUP model, the HEJA model and methods used in the analysis can serve as a guide upon which future competency updates can be designed. The regular, periodic re-verification of the health education responsibilities, competencies, and sub-competencies is a process that is iterative and necessary to ensure that certification, preparation and professional development are based on what is needed in current practice. In order to complete the next re-verification project within the recommended time frame of every 5 years, plans will need to begin again within the next year.

Health Educator Job Analysis Project Contributors

Professional Examination Service

The Professional Examination Service, New York, a nonprofit credentialing and competency assurance organization, was contracted to complete the 18-month project. The project sponsors are appreciative of the expert guidance of the following PES analysis experts.

Carla M. Caro, MA
Patricia M. Muenzen, MA
Professional Examination Service
Department of Research and Development
New York, NY

Health Educator Job Analysis Steering Committee

M. Elaine Auld, MPH, CHES; Chief Executive Officer, Society for Public Health Education
Eva Doyle, PhD, MEd, CHES; HEJA 2010 Task Force Chair, Baylor University
Linda Lysoby, MS, CHES, CAE; Executive Director, National Commission for Health Education Credentialing, Inc.
Beverly Saxton Mahoney, RN, MS, PhD, CHES; 2008 Coordinator, NCHEC Division Board for Certification of Health Education Specialists; Liberty University
Becky J. Smith, PhD, CHES, CAE; Executive Director, American Association for Health Education

Health Educator Job Analysis Task Force

Kelly Bishop Alley, MA, CHES; Centers for Disease Control and Prevention
Chesley Cheatham, MEd, CHES; MD Anderson Cancer Center
Eva I. Doyle, PhD, MEd, CHES; *Task Force Chair*; Baylor University
Lillie M. Hall, MPH, CHES; South Carolina Department of Health and Environmental Control
Mary Marks, PhD; California Department of Education
James F. McKenzie, MEd, MPH, PhD, CHES; Ball State University
Michael P. McNeil, MS, CHES; Alice! Health Promotion; Columbia University
Darcy Scharff, PhD; Saint Louis Univ. School of Public Health
Michael Stauffer, MA, CHES; StayWell Health Management
Alyson Taub, Ph.D., CHES; New York University
Carol A. Younkin, RN, MA, CHES; Eli Lilly & Company

Telephone Interview Panel

John Allegrante, PhD; Teachers College New York
Nancy Atmospera-Walch, RN, BSN, MPH, CHES; AIM Healthcare Institute
Karen Cottrell, MEd; Lakota Public School System
Gary Gilmore, PhD, CHES; University of Wisconsin-LaCrosse
James Grizzell, MA, MBA, CHES; California Polytechnic
Pamela Hoalt, PhD, LPC; Malone University
Jacqueline Valenzuela, MPH, CHES; Los Angeles Department of Public Health
Louise Villejo, MPH, CHES; M.D. Anderson Cancer Center
Carolyn Woodhouse, EdD, MPH; Georgia South University

Independent Review Panel

Edith Cabuslay, MPH; San Mateo County Health Department
Elizabeth H. Chaney, PhD, CHES; East Carolina University

Dixie L. Dennis, PhD, CHES; Austin Peay State University
Marcy Harrington, MPA, CHES; Region 6 Behavioral Healthcare
Jon W. Hisgen, MS, CHES; Wisconsin Department of Public Instruction
Judith A. Johns, MS, CHES; Kent State University
Linda LaSalle, PhD; University Health Services, Penn State University
Garry M. Lindsay, MPH, CHES; Partnership for Prevention
Kimberley McBride, MPH; Holy Cross Hospital
Larry K. Olsen, DrPH, CHES; New Mexico State University
Deyonne M. Sandoval, MS, CHES; New Mexico Department of Health
Audrey E. Shively, MSHSE, CHES; National Osteoporosis Foundation
Rob Simmons, DrPH, MPH, CHES; Thomas Jefferson University-Philadelphia
Cortney E. Smith, MS, CHES; American Cancer Society
Virginia Smyly, MPH, CHES; San Francisco Department of Public Health
Francisco Soto Mas, MD, PhD, MPH; University of Texas at El Paso
Carol A. Staubach, MPH; WellNow, Inc.
Jody R. Steinhardt, MPH, CHES; Henry Street Settlement

Pilot Test Participants

Dori Babcock, MA; Northwest Health & Wellness Institute
Janet Baggett, MA, CHES; Florida Department of Health
Christine E. Beyer, PhD; South Carolina Department of Education
Johanna Chase, CHES; North Carolina Department of Public Instruction
Chia-Ching Chen, EdD, CHES; New York Medical College
Lori Elmore, MPH, CHES; Centers for Disease Control and Health Promotion
Brian F. Geiger, PhD; Univ. of Alabama at Birmingham
Amanda Greene, CHES; Valley Preferred/Lehigh Valley Hospital and Health Network
Harpreet Grewal, MPH, CHES; Kaiser Permanente
Brent Hartman, MPH, CHES; Van Gilder Insurance Corporation
Marissa Howat, CHES; Rice University Wellness Center
Bernie Jarriel, MA, CHES; SeaView Community Services
Raffy R. Luquis, PhD, CHES; Penn State Harrisburg
Grace Miranda, MA, CHES; University of Puerto Rico-Medical Science Campus
Brandy Peterson, MPH, CHES; Arizona Department of Health Services
Tywanna Purkett, MA, CHES; Campus Wellness; East Carolina University
Susie Robinson, PhD, CHES; Health Educator, State of Oklahoma
Keiko Sakagami, EdD, CHES; New York City Department of Health
Jennifer Scofield, MA, CHES; Cleveland Department of Public Health
Jody Vogelzang, Ph.D., CHES; Liberty Christian School
Cathy D. Whaley, MA, CHES; School Wellness Project; Ball State University