Initiation of a Voluntary Certification Program for Health Education Specialists

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Synopsis

As health education has become a major strategy for addressing current health problems, the need for expertise in health education has increased. Today health education specialists work not only in health agencies and educational institutions but also in hospitals and other health and medical facilities, in businesses and industries, and in consulting firms. To promote quality assurance in the delivery of health education services to the public, the profession has launched a voluntary credentialing system for health education specialists. Seven areas of responsibilities and the competencies that they require have been delineated as generic to the practice of entry level health education specialists, regardless of the setting (for example, school, health agency, work site) where they work. The purposes and rationale for new National Commission for Health Education Credentialing, Inc., are described as well as the benefits of certification for the profession. The events and accomplishments of the past decade that have provided the foundation for the newly established credentialing program for the health education profession are chronicled.

With prevention becoming a national health priority, the public's enthusiasm for healthful lifestyles increasing, industries initiating health promotion programs, patients' being more involved in their medical care, and AIDS presenting new public health challenges, the need for quality health education has never been greater. The heart of the new perspective on improving health (*1*) is change in human behavior, which is the primary focus of quality health education. Numerous health education measures, for example, are delineated in the document "Promoting Health/Preventing Disease: Objectives for the Nation" (*2*).

The purpose of this article is to provide an overview of the new national certification program for individual health education specialists. As an important preliminary step to the certification program, health education specialists formulated a list of the broad responsibilities of generic entry level health education specialists. The chronology of the major accomplishments that provided the foundation for certification is detailed, and the purposes of the new National Commission for Health Education Credentialing, Inc., are described. The rationale for credentialing health educators, some of the credentialing issues, and recommendations for a national certifying organization have been previously published (*3*).

Launching the Certification Program

After a decade of building the foundation for a professional credentialing system, the health education profession has launched a program to certify individual health education specialists. This action does not imply that there is unanimous agreement among health educators. There is some disagreement, as has been the case with initiating credentialing in other professions. The first group of health education specialists were certified during the spring of 1989 through a chartering mechanism. Beginning in 1990, a competency-based examination will be the basis for certification of health education specialists. The voluntary certification

program will have an impact not only on health education specialists but also on their professional colleagues and the public whom they serve.

Being certified will indicate that a person meets the requirements of the newly established National Commission for Health Education Credentialing, Inc., for entry level competencies in health education. The basic competencies are the skills needed to carry out seven areas of responsibilities as they relate to issues of health and disease (see box). The responsibilities of health education specialists include the following: assessing needs for health education; planning, implementing, and evaluating health education programs; coordination; and communicating health and health education needs, concerns, and needed resources. The responsibilities are generic to all health education specialists regardless of the institution where they received professional preparation or the setting where they work; for example, school, hospital, health facility, or industry. Each responsibility includes functions or competencies that depend on clusters of essential skills (subcompetencies). Collectively, these skills are the core competencies that a professional entry level health education specialist should have. With more advanced professional preparation and experience, higher levels of competencies would be expected.

The voluntary professional certification program establishes a national standard for health education practice. The benefits of national certification include attesting to a person's knowledge and skills that are deemed essential to the field of practice as delineated by the profession, recognizing a commitment to professional standards, and providing recognition for practitioners. National certification will assist employers in identifying qualified practitioners and help assure consumers of the validity of services offered. Other long-range benefits include strengthening professional preparation programs, developing an organized system of continuing education, and promoting the skills of health education specialists among employers (*4*).

National Credentialing Body

To administer the certification program, the National Commission on Health Education Credentialing, Inc., has been established as a nonprofit, tax-exempt organization. The purposes of the commission are threefold: to certify health education specialists, to promote professional development, and to strengthen professional preparation. The commission will establish policies related to its purposes and administer programs to carry out the policies.

To expedite the formation of this organization, crucial for certification to begin, the Board of the National Task Force on the Preparation and Practice of Health Educators, Inc., became the interim board of directors for the commission. During the past decade, the task force has been working to establish a credentialing system for the profession. As task force members rotate off the board, they will be succeeded by members elected from the body of certified health education specialists from the various fields of practice—school, community, workplace, and academia. The elected board will consist of 12 members. Each member will serve a 5-year term and may not serve successive terms. Representatives from medical care, school, community, business and industry, and professional preparation program settings will be invited to stand for election. In addition, members of other health professions and consumers will be involved through work on various committees of the national commission.

The initial phase of the certification program of the National Commission for Health Education Credentialing, Inc., began in the fall of 1988 and ended in April 1989. The health education specialists certified during this initial phase will be known as Charter Certified Health Education Specialists. The method of recertification for the chartered group will be continuing education.

The initial charter phase was offered only through April 1989. Those not eligible for certification under the requirements delineated for this initial phase will be required to take a certification examination. The examination will be based on the seven areas of skills common to all health education specialists; it will be competency-based. Under a contract with the commission, the Professional Examination Service, Inc. (PES), is working with the profession to prepare an examination for the certification of health education specialists. PES is an independent national professional testing agency with 50 years of experience in developing credentialing examinations; it has specialized in the health care field.

Competency Measurement and Assurance

The measurement of competencies, the concepts of competency-oriented learning, and assurance of competency are important to the process of the new certification effort. Measurement of competencies, or criterion-referenced measurement, refers,

Seven Basic Responsibilities and Related Competencies of Health Education Specialists

Responsibility 1. Assessing individual and community needs for health education
Related competencies:
- Obtain health related data about social and cultural environments, growth and development factors, needs, and interests.
- Distinguish between behaviors that foster and those that hinder well-being.
- Infer needs for health education on the basis of obtained data.

Responsibility 2. Planning effective health education programs
Related competencies:
- Recruit community organizations, resource people, and potential participants for support and assistance in program planning.
- Develop a logical scope and sequence plan for a health education program.
- Formulate appropriate and measurable program objectives.
- Design educational programs consistent with specific program objectives.

Responsibility 3. Implementing health education programs
Related competencies:
- Exhibit competence in carrying out planned educational programs.
- Infer enabling objectives as needed to implement instructional program in specified settings.
- Select methods and media best suited to implement program plans for specific learners.
- Monitor educational programs, adjusting objectives and activities as necessary.

Responsibility 4. Evaluating effectiveness of health education programs
Related competencies:
- Develop plans to assess achievement of program objectives.
- Carry out evaluation plans.
- Interpret results of program evaluation.
- Infer implications from findings for future program planning.

Responsibility 5. Coordinating the provision of health education services
Related competencies:
- Develop a plan for coordinating health education services.
- Facilitate cooperation between and among levels of program personnel.
- Formulate practical modes of collaboration among health agencies and organizations.
- Organize in-service training programs for teachers, volunteers, and other interested personnel.

Responsibility 6. Acting as a resource person in health education
Related competencies:
- Utilize computerized health information retrieval systems effectively.
- Establish effective consultative relationships with those requesting assistance in solving health-related problems.
- Interpret and respond to requests for health information.
- Select effective resource materials for dissemination.

Responsibility 7. Communicating health and health education needs, concerns, and resources
Related competencies:
- Interpret concepts, purposes, and theories of health education.
- Predict the impact of societal value systems on health education programs.
- Select a variety of communication methods and techniques in providing health information.
- Foster communication between health care providers and consumers.

according to Popham (*5*), to a person's performance in relation to a stated criterion. The criterion usually is applied to a well-defined class of behaviors.

Competency-oriented learning has the following central characteristics: (*a*) specification of the learner's objectives in behavioral terms; (*b*) specification of the means for determining whether performance meets the indicated criterion levels; (*c*) provision for one or more models or instruments pertinent to the objectives, through which the learning activities may take place; (*d*) public sharing of the objectives, criteria, means of assessment, and alternate activities; (*e*) assessment of the learning in terms of competency criteria; and (*f*) placement on the learner of accountability for meeting the criteria (*5*).

The concept of a competency assurance program, originated by Margaret A. Wilson, PhD, Bureau of Health Professions, Health Resources and Services Administration, projected a structure capable of assuring the competency of the individual practitioner in the field (*6*). The components of such a program include role delineation, competency education, assessment of the practitioner, subsequent competency education, and practitioner evaluation.

This concept provided the model that the health education profession has been following in its efforts over the past decade.

A system for credentialing health professions is essential for the protection of consumers. Medicine and nursing, for example, have had credentialing systems for years in the form of licensure programs. A license to practice is an assurance to the public that the practitioner meets the minimum standards of a profession. Most health professions, however, have additional credentialing procedures. The goal is to assure quality services, rather than minimum standards. Dr. Wilson has stated:

> The public's right to quality health care requires that health practitioners be competent to carry successfully the responsibilities of the positions they seek to fill, and that the individuals seeking to practice must be evaluated as possessing the required expertise (*7*).

This concern for assuring the competency of health education specialists has been the major motivating force in the development of a credentialing system for health education specialists.

The two principal components of a credentialing system are an assessment of the individual practitioners and an evaluation of colleges and universities that provide professional preparation for the practitioners. The organizations of health education professionals have pursued both objectives, but only the development and status of the model for assessing individual practitioners is addressed in this paper. Following is a review of the accomplishments that have served as milestones in reaching the current status of the credentialing program.

Milestones in Developing Credentialing

The chronology (see next column) of significant accomplishments leading to the establishment of the certification program covers a decade. In this section we review the foundation work, including the First Bethesda Conference, the Five-Phase Credentialing Process, and the Second Bethesda Conference.

Most States require health education specialists working in secondary schools to be certified to teach health, similar to the certification of teachers of other subjects. However, there has been no other credentialing mechanism for individual health education specialists, except for a few States that have begun to register health education specialists according to their educational credentials.

Chronology Leading to a Credentialing System for Health Education Specialists

1978	Workshop on Commonalities and Differences in Preparation of Health Educators, Bethesda, MD (first Bethesda conference) Establishment of National Task Force on the Preparation and Practice of Health Educators Initial role specification
1980	Role verification and refinement
1981	National Conference for Institutions Preparing Health Educators, Birmingham, AL. Curriculum development
1983	Dissemination of revised document, "A Framework for the Development of Competency-Based Curricula for Entry-Level Health Educators" (*12*)
1984–85	Regional workshops on the "Framework"
1986	Workshop on Quality Assurance in the Delivery of Health Education Services: Credentialing the Health Education Specialist, Bethesda, MD (second Bethesda conference) (*13*)
1987	Development of model for continuing professional development of health education specialists
1988	Establishment of National Commission for Health Education Credentialing, Inc.

Approximately 300 colleges and universities offer academic preparation in health education, ranging from undergraduate to graduate course work and degrees (*8*). There are two national organizations of health education specialists: the Society for Public Health Education and the Association for the Advancement of Health Education, which is part of the American Alliance for Health, Physical Education, Recreation, and Dance. Six other national professional organizations identify health education as a major area of interest and include health education specialists among their members:

American School Health Association
Public Health Education Section of the American Public Health Association
School Health Education and Services Section of the American Public Health Association
Conference of State and Territorial Directors of Public Health Education
Society of State Directors of Health, Physical Education, and Recreation

Feedback from the field and input from workshop participants were used to revise the guide, which was published as "A Framework for the Development of Competency-Based Curricula for Entry-Level Health Educators." Some colleges and universities have already made changes in their curriculums, based on the delineation of the role of the health education specialist and the guidelines in the Framework.

Health Education Section of the American College Health Association

No one organization, however, represents a common voice or the position of the entire profession. The lack of a single lead professional organization has been a major impediment in the development and implementation of a credentialing system in the field, although the feasibility of a merger between the two national organizations for health education specialists is under consideration.

First Bethesda conference: identification of need. The work that led to the certification program began in 1978 when a group of health education specialists held a national conference entitled "Preparation and Practice of Community, Patient, and School Health Educators" (*9*). The conference, later called the First Bethesda Conference, was sponsored by the Bureau of Health Professions of the Health Resources Administration (now the Health Resources and Services Administration). The censensus of the 50 health education specialists attending was that health education specialists working in schools, community agencies, and medical care settings have enough in common to be included under the rubric of the health education profession.

An outcome of this meeting was the formation of the National Task Force on the Preparation and Practice of Health Educators, which was charged with the responsibility of pursuing the establishment of a credentialing system for the profession. Members of the task force have maintained ongoing communication with the eight national organizations having an interest in health education and over the years have worked toward attaining consensus on credentialing for the field.

Five-phase credentialing process. Following the 1978 Bethesda conference, the national task force, with the cooperation of the National Center for Health Education, sought and obtained funds from the Bureau of Health Manpower to begin work on a credentialing mechanism. The five-step process model that was adopted, as previously described (*10*), included the following:

1. role definition;
2. verification and refinement of the role;
3. preparation of an educational resource document for professional preparation programs;
4. development of self-assessment instruments for practitioners; and
5. preparation of materials and development of programs to assure continuing competencies through continuing education.

Role delineation and verification. The first two phases of the work were supported by Federal funding of the Role Delineation Project. The process required approximately 6 years to develop an acceptable generic role for entry-level health education specialists regardless of where they worked. After the role of health education specialists was delineated, verification was undertaken to determine whether the delineation was an accurate description of the work of health education specialists in a variety of settings.

Verification included several steps: a national survey of health education specialists working in medical care, school, college, and community settings; a workshop for faculty representatives of 86 colleges and universities in 36 States that prepare health educators (*11*); and feedback from participants at annual meetings of professional associations. As a result of these activities, the seven generic responsibilities of entry-level health education specialists were adopted (*12*).

When Federal funding was terminated in August 1981, after the completion of the first two phases, the national task force incorporated and continued efforts to establish a coordinated plan for credentialing of members of the profession. Individual health education specialists donated money and volunteered their services. Limited funds were raised from a private foundation, and many in-kind services were donated by professional associations, insurance companies, and other organizations.

Guidelines for academic preparation programs. The next step was the preparation of a curriculum guide to help faculties at colleges and universities preparing health education specialists to develop or modify their curriculums to be consistent with the verified role of the entry level health education specialist. The content of the guide was based on the verified role and results of a survey of academic institutions conducted in 1982.

The guide was pretested in fall 1984, and in spring 1985 workshops were held throughout the country. The Center for Health Promotion and Health Education of the Centers for Disease Control and the American Medical Association supported a training session for 12 workshop leaders in June 1984. These workshop leaders conducted regional workshops in conjunction with local organizations and professional groups. Feedback from the field and input from workshop participants were used in revising the guide, which was published as "A Framework for the Development of Competency-Based Curricula for Entry-Level Health Educators" (*12*). Some colleges and universities have already made changes in their curriculums, based on the delineation of the role of the health education specialist and the guidelines in the Framework.

A statement of the competencies has been provided to the Council on Education for Public Health, which accredits schools of public health and other university programs offering a master's degree in health education, and to the National Council for Accreditation of Teacher Education, which is the major accrediting body for teacher preparation programs, so that these accrediting organizations can use the competencies in reviewing health education programs. A voluntary peer review program for approval of undergraduate programs, adapted from a document developed by the Society for Public Health Education, Inc., is being sponsored by the society and by the Association for the Advancement of Health Education. All current official and nonofficial accrediting approval processes will be reviewed in an effort to foster uniformity in the accreditation of programs at all levels that prepare health education specialists.

Second Bethesda conference. In February 1986, the Second Bethesda Conference was held to update the profession on the credentialing process and to obtain the profession's views on the next steps. The proceedings of the conference has been published (*13*). The consensus of the 100 conference participants was that the task force should continue to developing a credentialing system for the certification of health education specialists and for some form of credentialing of the professional preparation programs. The participants directed the task force to continue its efforts to develop and implement quality assurance measures for the profession.

Beginning in 1990, a competency-based examination will be the basis for certification of health education specialists. The voluntary certification program will have an impact not only on health education specialists but also on their professional colleagues and the public whom they serve.

Continuing education. To facilitate continuing education efforts, the national task force, with funding from the Metropolitan Life Association, developed a model for continuing education for teachers of health in schools. A workshop to train trainers to use the model was held in the spring of 1987 in Reston, VA, and additional workshops are planned for other sections of the country. The model has been adapted to apply to all health education specialists in various types of work.

In addition, a self-assessment instrument is being developed to help health education specialists determine their own needs for further education and to prepare for the examination. The profession has now progressed through the stages of a credentialing process and has initiated a voluntary certification program for health education specialists.

Conclusion

As with any new national credentialing program, there are programs and policies to be developed and implemented as well as many issues to be addressed. Among the most important matters are those dealing with the quality of professional preparation, advanced professional education, accreditation of college and university programs that prepare health education specialists, recertification, and establishment of the role for more advanced levels of health education practice. Although the credentialing program has been launched, the system is still evolving. Decisions about emerging

issues will be made by the new board of directors of the commission, when they are elected by the newly certified health education specialists.

Most critical at this time, however, is an understanding of the new certification program not only by health education specialists but also by their colleagues and employers in public health, medical care, schools, colleges, and the work place. Discussions are being held at many national, State, and local meetings to inform the profession and other interested people. In addition, an instructional kit, containing overheads and handouts, has been developed by the national commission; it is available to assist persons who provide education about the commission and the credentialing system (*14*).

Credentialing will enable health education specialists to delineate their expertise, define their scope of practice, and identify the body of knowledge upon which their work is based. Employers will have an objective basis for evaluating applicants, assessing performance, and determining appropriate expectations of a professionally prepared person. Consumers will have assurance that a certified health education specialist has attained a specified level of competency. Thus, credentialing has the potential for benefiting employers and consumers as well as health education specialists.

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