

## Assessment of Public Health Education Practice: Health Educator Responsibilities

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### **Abstract:**

This study presents a method for better understanding how practicing health educators in local health departments spend their time. The purpose of this study was to document the daily practice of health educators in the 10 areas of responsibility as defined by a competency-based framework for graduate-level health educators. The results of the current study present the average percentage of time health educators spent carrying out each area of responsibility and the percentage of health educators that did not carry out activities related to a specific area of responsibility. For example, the greatest percentage of time was spent implementing programs (21.2%), and approximately 60% of the health educators in the sample did not conduct research nor did they participate in activities to advance the profession. These findings have implications for the professional preparation of health educators and for their continuing education. The current study contains several suggestions for future research in this area.

**Keywords:** public health | public health education | public health educator practice | public health educator responsibilities | local health departments | health promotion

### **Article:**

What do practicing health educators do? Documenting the daily practice of health educators has a variety of uses. The information gathered from this process can be used in the academic preparation of health educators, for continuing education, and more pragmatically to advocate for the increased inclusion of health education in public health and for increased state and local support of health education practitioners and programs. The purpose of the current study was to document the daily practice of health educators in an effort to evaluate the real-life applications of the 10 areas of responsibility as defined by A Competency- Based Framework for Graduate-Level Health Educators (National Commission for Health Education Credentialing, 1999).

The past several years have witnessed the steady development and defining of health education practice. This evolution, beginning in the 1970s, is detailed by Taub (1998) and Cleary (1995). Milestones during this time included the initiation of the Role Delineation Project (U.S.

Department of Health, Education & Welfare, 1978), the release of A Framework for the Development of Competency-Based Curricula for Entry-Level Health Educators in 1985 (National Task Force on the Preparation and Practice of Health Educators, 1985), and the preparation of a national credentialing system for the health education profession (Cleary, 1995). These events have formed the basis for the credentialing of health educators as well as curricula for the professional preparation of health educators (Schwartz, O'Rourke, Eddy, Auld, & Smith, 1999). In 1999, the National Commission for Health Education Credentialing, the American Association of Health Education, and the Society for Public Health Education published A Competency-Based Framework for Graduate-Level Health Educators. This document provides an overview of the development of health education responsibilities and competences and presents the most recent description of entry-level responsibilities and competencies for health educators along with the responsibilities and competencies of the graduate-prepared health educator (National Commission for Health Education Credentialing, 1999). Using the framework provided in this document to forecast and anticipate future health educator responsibilities and competencies is important to designing academic and continuing education programs (Allegrante, Moon, Auld, & Gebbie, 2001). As well, knowing the day-to-day practice of health educators allows university personnel to be responsive to the current needs of health educators (Knight, 1991). In the same vein, those providing continuing education, such as state-level health education consultants and administrators, and state and national health education professional associations, need to be responsive to the current needs and circumstances of practicing health educators. To date, little research has been reported to document how health educators practicing in community settings meet these responsibilities.

In the spring and summer of 2001, health educators in local public health agencies in North Carolina were surveyed to document their daily practice. The areas of responsibility as described in the Competency-Based Framework for Graduate-Level Health Educators (National Commission, 1999) provided the theoretical and analytical basis for this investigation. This framework was chosen because it represents the most recent description of entry-level responsibilities and competencies for health educators along with the responsibilities and competencies of the graduate-prepared health educator. These areas of responsibility are

- assessing individual and community needs for health education Examples: obtain/analyze health-related data, identify priorities
- planning effective health education programs Examples: recruit participation, formulate objectives, design action plans, design marketing strategies
- implementing health education programs Examples: design/test methods/materials, teach/facilitate activities, monitor programs
- evaluating effectiveness of health education programs Examples: develop/carry out evaluation plans, analyze data, write reports
- coordinating provision of health education services Examples: grassroots organizing, coalition/partnership building, provide in-service training

- acting as a resource person in health education Examples: access/respond to requests for health information, provide consultation
- communicating health and health education needs, concerns, and resources Examples: media coordination, public speaking, prepare written materials/documents
- applying appropriate research principles and methods in health education Examples: conduct literature searches, use research findings, conduct research
- administering health education programs Examples: prepare grant proposals, manage budgets, recruit/evaluate/supervise personnel
- advancing the profession of health education Examples: policy advocacy, support professional organizations, promote ethical practice

The research reported here is part of a larger study on health education practice in North Carolina. Conducting this inquiry in North Carolina was particularly fruitful because (a) most of the state's local public health agencies employ health educators; (b) there are nine health education degree programs in the state's colleges and universities, and many of the programs' graduates are employed in local public health agencies; and (c) the state's division of public health has a strong organizational structure for the development and support of health education and health promotion initiatives including an Office of Healthy Carolinians and Health Education, and a Health Promotion and Disease Prevention Section. In North Carolina, each of the 86 locally controlled health departments has statutory authority to serve one or more of the state's 100 counties. Seventy-eight are single county agencies, and eight agencies serve multiple counties.

## METHOD

### Procedure

Questionnaires were mailed to all health educators employed in North Carolina local health departments using a list of health educators that is routinely updated by the North Carolina Division of Public Health. Respondents were informed that their responses would remain confidential; however, an identifying number was used to track responses. Follow-up with non-respondents was done over a 2-month period, first by re-mailing the questionnaire, then by e-mail contact including a copy of the questionnaire, and finally by telephone requests.

### Measures

Following conversations with the state director of health education, regional health education consultants, and practicing health educators, a draft of the questionnaire was developed. The collaborating partners reviewed the questions for clarity, and a revised questionnaire was pilot tested with graduate health education students and four practicing North Carolina local health educators in one local health department. This process provided estimates of time required to complete the questionnaire in addition to a critique of the questionnaire's content and the clarity of questions. Based on their feedback, a revised questionnaire, including the cover letter, was

sent to the University and Medical Center Institutional Review Board for approval (study approval number UMCIRB #99-0087). Although four of the individuals participating in the pilot test also completed the final questionnaire, the study is descriptive, and this should not be a threat to the validity of the data.

In particular, the current study was designed to measure the extent to which public health educators are involved in activities related to the 10 areas of responsibility outlined by A Competency-Based Framework for Graduate-Level Health Educators (National Commission, 1999). Respondents were requested to approximate the percentage of their time during the past year that they spent carrying out each of the areas of responsibility. If the 10 areas of responsibility did not completely capture how they spent their time, they were invited to list other tasks they had. The total percentage of time, across all 10 areas of responsibility, was to equal to 100%.

In addition, the current study was designed to measure the influence of agency size, number of health educators employed by an agency, educational attainment including certified health education specialist (CHES) certification, length of employment, and administrative and supervisory responsibilities on each of the 10 areas. These variables were categorized as organizational variables or individual variables.

**Organizational variables.** Data was collected on the following organizational variables to assess whether any of them were associated with the job responsibilities reported by the respondents. First, respondents were asked the size of their local public health agency using total number of full-time equivalents (FTEs). Local public health agencies employing less than 100 FTEs were categorized as small; health agencies employing 100 or more FTEs were categorized as large. Second, to determine whether a specific health educator practiced as a sole health educator or alone, the number of health educators employed in an agency was collected.

**Individual variables.** These variables fall into the following two groups: training and experience, and administration and supervision. Questions regarding the training and experience of health educators asked: (a) if they were a CHES, (b) if they had a degree in health education, (c) the level of their degree in health education (bachelor's, master's, doctorate), and (d) how long they had been employed (categorized as new if less than 2 years experience; categorized as seasoned if more than 2 years of experience). Questions regarding the administration of health education programs and the supervision of staff asked (a) whether they administered a program, (b) whether they supervised other staff, and (c) if they were supervised by either a health educator or other staff member.

## Analysis

Descriptive statistics were used to examine the percentage of time health educators spent carrying out tasks associated with each health education responsibility. The independent-samples

t test for equality of means was used to examine the relationships among percentage of time spent on each responsibility and the organizational and individual variables.

## RESULTS

The current study resulted in a description of how practicing health educators in local health departments spend their time. Results came from a survey of all health educators employed in local health departments in North Carolina in the spring and summer of 2001. Participants in the study returned completed questionnaires by mail or electronically. In all, 297 health educators employed in the 86 local public health agencies in North Carolina received the questionnaire; 204 health educators returned completed questionnaires for a response rate of 68.7%.

Respondents were requested to approximate the percentage of their time during the past year that they spent carrying out each of the areas of responsibility. If the 10 areas of responsibility did not completely capture how they spent their time, they were invited to list other tasks they had. The total percentage of time, across all 10 areas of responsibility, was to equal 100%. Of the 198 health educators who completed this question, five listed other tasks they had. However, when asked to assign a percentage of time dedicated to each of the areas of responsibilities, their total percentage time for the 10 areas of responsibility equaled 100 percent.

Table 1 presents the average percentage of time health educators spent carrying out each area of responsibility and the percentage of health educators who did not carry out activities related to a specific area of responsibility. The greatest percentage of time was spent implementing programs (21.2%). On average, health educators spent approximately the same percentage of time planning (13.3%), communicating (12.9%), administering programs (11.5%), coordinating services (11.4%), and acting as a resource person (10.2%). They spent the least percentage of time assessing needs (7.8%), evaluating programs (6.3%), conducting research (2.8%), and advancing the profession (2.3%). In addition, approximately 60% of the health educators in the sample did not conduct research nor did they participate in activities to advance the profession. Moreover, 27.8% of these health educators were not involved in assessing individual and community needs, and several health educators (22.7%) were not involved in evaluating health education programs. By contrast, the majority of public health educators reported involvement in planning health education programs (87.9%), implementing programs (89.4%), acting as a resource person (89.4%), and communicating needs (88.4%).

**Tables 1 & 2 are omitted from this formatted document.**

### Analysis of Variables

Variables important to the current study were organized into organizational variables and individual variables. Table 2 presents general information related to these two categories of variables.

Organizational variables. The sample included health educators from agencies with 100 and less employees (smaller agencies = 41.3%) and from larger agencies (58.7%). The sample also included individuals who were the only health educator on staff (13.2%) and health educators with multiple in-agency colleagues (86.8%). Table 3 presents only the significant results for these two variables. Table 4 presents the percentage of health educators employed in smaller agencies and the percentage of lone health educators who participated in the areas of responsibility.

A greater percentage of health educators from smaller local health departments were involved in assessing individual and community needs compared to those employed in larger local health departments (80.2% and 66.1%, respectively), and the health educators employed in smaller local health departments spent more time carrying out this responsibility ( $M = 9.4$  compared to  $M = 6.7$ ,  $p < .03$ ). Of all the areas of responsibility, health educators spent the least amount of time advancing the profession of health education (2.3%). However, health educators in larger agencies did spend more time carrying out this area of responsibility than did health educators in smaller agencies ( $M = 2.7$  compared to  $M = 1.6$ ,  $p < .03$ ).

All the lone health educators reported involvement in assessing individual and community needs, whereas 68% of health educators with multiple in-agency colleagues reported involvement with this area of responsibility, and lone health educators spent more time carrying out the responsibility ( $M = 10.3$  compared to  $M = 7.5$ ,  $p < .04$ ). All but one of the lone health educators reported involvement in implementing health education programs. More interesting, however, those health educators with multiple in-agency colleagues spent more time carrying out this area of responsibility ( $M = 22.0$  compared to  $M = 15.6$ ,  $p < .02$ ). In addition, health educators with multiple in-agency colleagues spent nearly twice as much time administering health education programs compared to lone health educators ( $M = 12.3$  compared to  $M = 6.6$ ,  $p < .01$ ). With few exceptions, a greater percentage of health educators from smaller agencies and a greater percentage of lone health educators were involved in carrying out the areas of responsibility than were health educators from larger agencies and those with multiple in-agency colleagues.

Individual variables. The sample included individuals that were CHES certified (12.3%). In terms of formal training, approximately 7 in 10 of the respondents (71.1%) had degrees in health education, and several had master's degrees (40.1% with 29.4% having a master's degree specifically in health education). In addition, the sample included a mix of new health educators (26.7%) and health educators with more than 2 years of experience (73.3%). Table 5 presents the significant results associated with these training and experience variables.

Of the health educators responding to this survey, 12.3% were CHES certified. Although small in number, these individuals spent more time administering health education programs compared to those health educators without CHES certification ( $M = 17.5$  compared to  $M = 10.7$ ,  $p < .05$ ). The majority of health educators in the sample held degrees in health education (71.1%), however, individuals without a degree in health education (28.9%) spent more time

implementing health education programs than those with degrees in health education ( $M = 25.6$  compared to  $M = 19.4$ ,  $p < .04$ ).

Health educators with master's degrees (40.1%) spent more time assessing individual and community needs for health education ( $M = 9.7$  compared to  $M = 6.6$ ,  $p < .01$ ), coordinating provision of health education services ( $M = 13.6$  compared to  $M = 9.8$ ,  $p < .03$ ), and administering health education programs ( $M = 14.7$  compared to  $M = 9.6$ ,  $p < .03$ ). Conversely, health educators with bachelor's degrees spent more time implementing health education programs ( $M = 24.2$  compared to  $M = 16.8$ ,  $p < .01$ ) and communicating health and health education needs, concerns, and resources ( $M = 14.4$  compared to  $M = 10.7$ ,  $p < .05$ ).

With the exception of administering health education programs, length of employment did not significantly affect the amount of time health educators spent carrying out the responsibility areas. As expected, seasoned health educators (those with 2 or more years of experience) spent more time administering health education programs than new health educators ( $M = 13.8$  compared to  $M = 5.5$ ,  $p < .001$ ).

Additional individual variables included those associated with the administration of health education programs and supervision. Those completing the survey were requested to describe their current position as primarily administrative, primarily direct health education service delivery, or administrative and direct service delivery. Close to two thirds of the sample (62.7%) indicated that their positions were primarily administrative or administrative and direct service. Survey participants were also requested to provide their current position title and the position title of their supervisor. Almost one fifth (16.7%) of the sample were supervisors, and close to one half (47.3%) were supervised by a health educator. Table 6 presents the significant results associated with these variables.

**Tables 3 & 4 are omitted from this formatted document.**

A greater percentage of health educators with administrative responsibilities for programs compared to those with no administrative responsibilities for programs were involved in assessing individual and community needs (79.7% and 60%, respectively), and health educators with administrative responsibilities for programs spent more time carrying out this area of responsibility ( $M = 8.8$  compared to  $M = 6.3$ ,  $p < .04$ ). Health educators with administrative responsibilities also spent more time evaluating the effectiveness of health education programs ( $M = 6.9$  compared to  $M = 5.3$ ,  $p < .05$ ) and coordinating the provision of health education services ( $M = 13.2$  compared to  $M = 8.5$ ,  $p < .01$ ). Conversely, health educators without administrative responsibilities (37.3% of the sample) spent more time implementing health education programs ( $M = 29.6$  compared to  $M = 16.1$ ,  $p < .001$ ) and more time acting as a resource person in health education ( $M = 12.8$  compared to  $M = 8.7$ ,  $p < .02$ ).

A greater percentage of health educators with supervisory positions compared to those with no supervisory responsibilities were involved in assessing individual and community needs (91.4%

and 68.1%, respectively), and health educators with supervisory responsibilities spent more time carrying out this area of responsibility ( $M = 10.4$  compared to  $M = 7.3$ ,  $p < .04$ ). As expected, those individuals who were not supervisors spent more time implementing health education programs ( $M = 24.2$  compared to  $M = 7.2$ ,  $p < .001$ ), and those health educators who were supervisors spent more time administering health education programs ( $M = 28.6$  compared to  $M = 7.9$ ,  $p < .001$ ).

More interesting, health educators who were not supervised by another health educator spent more time assessing individual and community needs ( $M = 9.6$  compared to  $M = 6.1$ ,  $p < .01$ ) and administering health education programs ( $M = 15.5$  compared to  $M = 7.4$ ,  $p < .001$ ). Those health educators who were supervised by a health educator spent more time implementing programs ( $M = 25.2$  compared to  $M = 17.0$ ,  $p < .01$ ).

## DISCUSSION

The results of the current study provide a look at what public health educators are doing in the public health practice setting. Participants in the study were asked to approximate the average amount of time, during the past year, they spent carrying out each area of responsibility. If the 10 areas of responsibility did not completely capture how they spent their time, they were invited to list other tasks they had. Of the 198 health educators who completed this question, five listed other tasks they had. However, in all cases, they realized that the tasks they listed fit into the areas of responsibility, and their total percentage time for the 10 areas of responsibility equaled 100%. This outcome supports the use of A Competency-Based Framework for Graduate-Level Health Educators (National Commission, 1999) as a research tool for documenting the practice of public health educators. An implication of this finding is that the framework could be used to survey health educators who work in settings other than public health departments, for example, workplaces, schools and universities, and health care.

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Health educators reported on the percentage of time they spent carrying out the 10 areas of responsibility with the greatest percentage of time spent implementing programs (21.2%) and the least amount of time advancing the profession (2.3%). These results do not depict the relative importance of these areas of responsibility; that is, based on information gathered in the current study, one cannot say that implementing health education programs is more important to a practicing health educator than advancing the profession. To provide a more complete picture of how health educators carry out the areas of responsibility, the authors suggest that future research using the framework investigate the opinions of health educators on the frequency and importance of each of the areas of responsibility in their day-to-day practice.

The results of the current study highlighted the situation of lone health educators (the only health educator in an agency) and health educators employed in small agencies. All the lone health educators in the sample reported being involved in three of the areas of responsibility (assessing

individual and community needs, planning health education programs, and communicating health and health education needs, concerns, and resources). Furthermore, the general tendency was that a greater percentage of lone health educators and those from smaller agencies were involved in carrying out most all the areas of responsibility than were health educators with multiple in-agency colleagues and those from larger agencies. This casts the lone health educator and health educators in smaller agencies as “generalists” meaning they are called on to perform across all the areas of responsibility and demonstrate a wide variety of health education competencies. This result is confirming in that it supports the wisdom and intent of the areas of responsibility as a structure for training and certifying all health educators. Furthermore, this result suggests that research is warranted with health educators who have greater specialization.

Approximately 25% of health educators in this sample spent no time assessing individual and community needs for health education and no time evaluating the effectiveness of health education programs. Furthermore, approximately 60% of health educators in the sample spent no time applying appropriate research principles and methods in health education and no time advancing the profession of health education. These findings are of particular importance to those providing professional and continuing education to health educators. Research is needed, as stated earlier, on how health educators rate the importance of these areas of responsibility to their practice. In addition, it would be interesting to gather data from those health educators who do assess, evaluate, and apply research principles.

All these suggestions for further research should be extended to public health educators, health educators practicing in other settings (e.g., workplace, schools and universities, health care), and health educators in other states. The current study was done in North Carolina where there is at least one health educator in each local health department and where each county is served by a health department. It may be interesting to investigate the responsibilities of public health educators working in other state public health structures.

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