Public Health Educators' Participation in Teams: Implications for Preparation and Practice.

By: Kay Lovelace, Daniel Bibeau, Brigid Donnell, Hans Johnson, Mary Glascoff and Emily Tyler

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Abstract:

Collaboration among public health organizations is essential to ensuring the health of the public. Much of the day-to-day work of public health educators is done in groups or teams or in consultation with others. This study examined the extent of health educators' work in teams as a proxy for collaboration. Health educators participated in an average of four teams per individual; three of these were interorganizational teams. Moreover, 40% of the respondents participated in five or more teams. Health educators supervised by other health educators were more likely to work in interorganizational teams than were those supervised by other professionals. Certified Health Education Specialists were more likely to participate in intraorganizational teams. Curricula in academic programs should reflect the extensive teamwork in which health educators are involved. Employers need to provide health educators with grounding in organizational priorities and support to carry out their collaborative work.

Keywords: professional preparation | health educators | health education | public health | interorganizational collaboration | health promotion

Article:

Collaboration among public health organizations is critical to ensuring the health of the public. According to the 1988 Institute of Medicine report, public health is “what we as a society do collectively [italics added] to assure the conditions in which people can be healthy.” Similarly, the 2003 Institute of Medicine report titled The Future of the Public’s Health in the 21st Century calls for building a new generation of intersectoral partnerships that draw on the perspectives and resources of diverse communities and actively engage them in health actions that enhance and facilitate communication within the public health system (i.e., among all levels of the governmental public health infrastructure and between public health professionals and community members). The Centers for Disease Control and Prevention and other public health

researchers are promoting evaluation of how the system of public and private organizations responsible for community health performs (Baker et al., 2005; Bakes-Martin, Corso, Landrum, Fischer, & Halverson, 2005; Lenaway et al., 2006). One of the essential public health services considered in the public health system performance framework is mobilizing community partnerships to identify and solve health problems. Broad movements known by the names Healthy Cities and Healthy Communities have encouraged collaboration through community-wide coalition building (Norris & Pittman, 2000; Wolff, 2001, 2003), and other types of coalitions have focused on pulling together diverse community actors to address complex health problems such as asthma, immunizations, lead poisoning, and tobacco, alcohol, and drug abuse (Butterfoss, Kelly, & Taylor-Fishwick, 2005; Butterfoss et al.,1998; Clark et al., 2006; Fawcett et al.,1997; Freudenberg & Golub, 1987; Kegler, Steckler, McLeroy, & Malek, 1998; Kuhn, Doucett, & Edwards, 1999). Further, federal agencies are demanding that interventions involve interdisciplinary and interorganizational teams so that a broader array of expertise can be brought to the table to address health problems.

In the public health system, health educators typically develop and carry out planned health promotion and disease prevention programs with individuals, groups, organizations, and communities. They do this by using "any combination of learning methods/experiences designed to facilitate voluntary adaptation of behavior conducive to health" (Green, 1984). To be effective, health educators must be able to work collaboratively with community members and other professionals. The need for collaborative work by health educators can be seen in two documents developed by a consortium of health education organizations that have published work-related responsibilities and competencies of health education practice. A Framework for the Development of Competency-Based Curricula for Entry Level Health Educators (Cleary, 1995) was the initial basis for health education credentialing and the Certified Health Education Specialist (CHES) designation. Recently, the Competencies Update Project revised the areas of practice and published A Competency- Based Framework for Health Educators—2006 (National Commission for Health Education Credentialing, 2006), based on a multiphase research project. More than 400 health educators in 50 states and the District of Columbia completed a self-assessment related to how frequently they performed each skill, the amount of time needed to carry out each one, and relevant demographic data (Gilmore, Olsen, Taub, & Connell, 2005).

Both documents show that much of the day-to-day work of health educators is done in groups or teams or in consultation with others. For example, Area II in A Competency-Based Framework for Health Educators— 2006 gives health educators a framework for planning strategies, interventions, and programs. Competency A in Area II states that health educators should be able to involve people and organizations in program planning. Competency B in Area I focuses on collecting health-related data; although this competency does not directly address working with others, many approaches to health education and health promotion (e.g., the Healthy Communities movement and community-based public health) recommend that public health professionals collaborate with community members and groups to identify appropriate questions,

develop or identify measures, and perform needs assessments. And certainly, health educators will call on other professionals (e.g., biostatisticians) to assist with aspects of the work in which they are less versed. Simply stated, collaboration is an essential part of the health educator's professional practice.

Still, little is known about how much collaborative work health educators do. This article reports a study that addressed this question by examining public health educators' participation in intra- and inter-organizational teams. We conclude with implications for professional preparation and practice.

METHOD

Sampling Procedure

Using Dillman's (2000) mail survey method, we mailed questionnaires to all health educators employed in North Carolina's 86 locally controlled health departments. Participants were informed that their responses would remain confidential but that we would use an identifying number to track responses. We followed up with nonrespondents during a 2-month period, first by remailing the questionnaire, then by e-mail contact that included a copy of the questionnaire, and finally by telephone.

Measures

Based on the public health workforce literature and conversations with leading public health education officials and other practicing health educators, we developed a draft questionnaire, revised it on the basis of feedback, and pilot tested the revised questionnaire with graduate health education students and four practicing North Carolina local health educators in one local health department (LHD). Based on their feedback, we revised the questionnaire and submitted the study proposal and questionnaire to the institutional review boards at East Carolina University and the University of North Carolina–Greensboro. Both boards approved the study.

In the questionnaires, we asked about health educators' participation on intra- and interorganizational teams, their role on the teams, and the number of times per month that the teams met. Specifically, we asked respondents to give the name or purpose of up to five teams in which they participated and to indicate whether the team was an inter-organizational team or a team within the agency, whether the team was informal or formal, whether their membership was voluntary or assigned, the number of times per year the team met (1-2 times yearly, 3-4 times yearly, 5-12 times yearly, or more than 12 times yearly), and their role on the team (leader, member, or staff). On the basis of health educators' reports of the number of yearly meetings they attended per team, we calculated a range for each health educator (minimum to maximum number of team meetings per year).

We also asked about the training and experience of respondents, specifically (a) whether they were CHESs, (b) their degree majors, and (c) the level of their degree(s) (bachelor's, master's, or doctorate). Health educators were considered to have formal training in health education if they reported their major to be health education, community health education, health promotion, school health, worksite health promotion, or public health education. Organizational questions asked how health education was structured and administrated in the LHD (e.g., the discipline of the health educator's supervisor), how many health educators were employed by the agency, and the size of the jurisdiction served by the agency.

Data Analysis

We developed an initial categorization scheme for all the teams in which health educators participated, including (a) administrative committees (e.g., LHD committees such as management teams and quality assurance teams), (b) comprehensive prevention-focused community collaborative efforts such as Healthy Carolinians (the North Carolina version of the Healthy Communities movement), (c) health problem or issue-specific teams (e.g., environmental health, chronic disease, violence, injury prevention teams), (d) population-focused teams (e.g., teams focused on women and children or on cultural diversity), (e) interagency collaboration or nonprofit board and support, and (f) miscellaneous (teams for which there was insufficient information for classification). Two raters independently placed each team in a category. When there was disagreement, the raters negotiated a common categorization for the team. We used descriptive statistics to describe the health educators' participation on intra- and inter-organizational teams, their roles on the teams, and the frequency with which they participated in team meetings.

We used the responses to the question on the number of team meetings per year (by category) and developed a count of the possible range of minimum number of team meetings per year for each health educator and the possible range of maximum number of team meetings per year. We used one-way analysis of variance to determine how the health educators' participation in teams varied by their characteristics and their organization's characteristics.

RESULTS

Respondents

In all, 297 health educators employed in the 86 local public health departments in North Carolina received the questionnaire; 205 health educators returned questionnaires, and 192 completed the questions on teams. This resulted in a response rate of 64.6% for health educators' experience with teams. Of the 86 local public health departments, 83 were represented in the final sample. At the time of the survey, 2 of the 86 local public health departments did not employ a health educator, and one department's sole health educator did not respond.

Types of Teams

Health educators listed membership in 737 teams. As shown in Table 1, respondents participated most frequently in population-based teams (31% of teams); 27% were problem- or issue-specific teams; 14% of teams were comprehensive, prevention-focused community collaborations; 12% were administrative in nature (most were internal to the health department); 6% were interagency task forces or nonprofit boards; and 9% could not be categorized (mostly because of insufficient information).

Number of Team Memberships

Table 1 is omitted from this formatted document.

Overall, health educators participated in an average of 3.84 teams each, about one team in their agency and three interorganizational teams (Table 2). Many (60%) of the health educators participated in at least one team within their health department; 8.4% participated in three or more. Health educators participated in more formal (3.10 each) than informal teams (0.73 each), and their membership on all teams was more frequently assigned (2.15 teams each) than voluntary (1.68 teams each). In all, 95% of the respondents also participated in at least one inter-organizational team. About a third participated in one or two inter-organizational teams, and the majority, 63%, participated in three or more inter-organizational teams. More than a third of respondents were members of four or more inter-organizational teams. An analysis of health educators' roles on inter-organizational teams (member, leader, or staff role) found that 52% served as leader on one team, and 17.7% were leaders on two or three inter-organizational teams. In addition, 14% of respondents served as staff for at least one inter-organizational team, and 5% served as staff for two or three inter-organizational teams; 86% of respondents were members (only) of at least one inter-organizational team; 87% were members (only) of two or more inter-organizational teams.

Team Meetings

On average, health educators participated in a minimum of 19 team meetings per year and a maximum of 36 meetings per year. The lowest 20th percentile of the sample participated in 11-20 meetings per year or fewer; however, the highest 20th percentile participated in 28-52 meetings per year or more. Overall, respondents reported that 13% of the teams on which they participated met more than 12 times per year; 60% met 5-12 times per year; 25% met 3-4 times per year; and 3% met only 1-2 times per year.

Participation in Teams by Health Educator and Agency Characteristics

Tables 2 & 3 are omitted from this formatted document.

Using one-way analysis of variance, we conducted an analysis of team membership by degree level, type of supervisor, number of health educators in the agency, health education degree, CHES certification, position title, and jurisdiction population; the results are shown in Table 3.

Participants who were supervised by health educators were more likely to participate in inter-organizational teams than were those without health educator supervisors, $F = 11.588$, $p < .001$. Those who were the only health educators in their department were more likely to participate in inter-organizational teams than were those whose organizations had multiple health educators, $F = 3.918$, $p < .049$. CHES-certified health educators were more likely than those not certified to participate in teams within their health departments, $F = 4.524$, $p < .035$. Those in jurisdictions with populations of less than 50,000 were least likely to participate in teams in their health department, $F = 3.335$, $p < .038$.

DISCUSSION AND CONCLUSION

Our findings provide a snapshot of public health educators' participation in various types of teams. These public health educators' collaboration with others (as defined by team membership) averaged about four teams per health educator. This is probably a low estimate because the questionnaire provided response options for only five teams, and 41% of the sample reported membership in at least five teams. We do not know how many of these respondents served on more than five teams. Most of these health educators' team efforts occurred in inter-organizational teams. Thus, in addition to serving as ambassadors for their agency, they doubtless contributed pertinent information to their agency about other organizations in the community, including an assessment of others' missions, goals, strengths, and limitations, and also formed relationships that could be called on when necessary to resolve a public health issue or disaster. They probably also learned more about the health status, needs, and assets of the different constituencies they served and the feasibility of specific public health interventions given the constituencies and partners with whom they worked. More than half (52%) of the respondents served as leaders and 14% were staff members of at least one interagency team, suggesting the significant leadership role of the profession. Most of the teams reported by these health educators tended to focus on public health matters: specific populations (31%—primarily women, children, and adolescents), specific health issues (27%), or comprehensive community-based collaborations (14%—primarily local Healthy Carolinians task forces). Thus, the public health educators served as a community presence for the health department in addressing a community's health needs and were essential in ensuring that the public health agency provided essential public health services.

The findings on the number of team memberships (about four per health educator) as well as the number of team meetings (on average, 19-36 per year per health educator) suggest that health educators spend a significant portion of their time in meetings. Although the health educators participated in assigned teams more than in voluntary teams, on average they were volunteering for about two teams each. The amount of time spent working collaboratively could have implications for the individual's and the organization's effectiveness. On one hand, participation in these inter-organizational and intra-agency groups may help health educators gain important information about the community. On the other hand, not all these partnerships are likely to be

effective, and attending meetings of partnerships that are ineffective can be a drain on the energy and time of health educators and a poor use of organizational resources.

Taken together, these findings have implications for academic programs in health education, for professional organizations, and for employers. Academic programs in community health education need to be cognizant of the significant role of health educators in working collaboratively to promote the community's health. Thus, the curriculum of these programs should include skill building in teamwork, facilitation, networking, community capacity building, and forming and using partnerships, as well as information gleaned from the literature on characteristics of the most effective leaders, members, and staff for coalitions and other teams and information about how to understand community structure and power dynamics (e.g., see CDC/ATSDR Committee on Community Engagement, 1997; Francisco et al., 2001; Kegler et al., 1998; Mattessich, Murray-Close, & Monsey, 2004; McKnight, 1995; Mintzberg, Dougherty, Jorgensen, & Westley, 1996).

The findings also suggest actions that professional organizations such as the Society for Public Health Education and the American Public Health Association might take to enhance the ability of health educators and other public health professionals to serve as members of inter-organizational teams. These actions could include providing workshops on teamwork and collaboration skills at national meetings, developing tool kits and assessment tools for individuals and for the groups with which they work, and providing continuing education units for professionals who undertake the development of these skills (e.g., see Society for Public Health Education, 2005).

The finding that health educators are involved in a significant amount of inter-organizational teamwork suggests actions that employers wanting to promote collaboration might take, including hiring health educators from programs that address health educators' areas of responsibility. In addition, health educators who are responsible for inter-organizational collaboration should be well versed in their department's mission, goals, and priorities so that the collaborations undertaken are purposive. Not all collaboration will be in alignment with the health department's mission, and not all will be effective, but all take time. Therefore, it is important to direct health educators' energies to collaborative efforts with clear purposes that further the organization's mission (Green, 2000). To do otherwise wastes valuable time and effort and takes away from other efforts that could be effective.

Health educators should be allotted time for establishing the relationships necessary for collaboration, and once they are involved in a collaborative effort, they should have the authority (and clear limits within which to operate) to commit their organization's effort to the collaboration. As teams or coalitions move forward and develop their implementation plans, their efforts should be expected to be more time intensive. Finally, it is important to build in health educators' access to the leadership structure within their own organization (e.g., management

teams) and other internal groups where they can both learn about their organization's experience with various community partners and share their own experience.

This research used team membership as a proxy for collaborative work by health educators. We do not know how much effort these teams required beyond the simple measure of number of meetings. Further, our research says nothing about the effectiveness and the overall benefit to the community and the agency of collaborative efforts in which health educators are engaged. Although coalitions and community partnerships are widely promoted, it is important for health educators to attend to the possible limitations, costs, and negative consequences of such partnerships (e.g., see Berkowitz, 2001; Chavis, 2001; El Ansari & Phillips, 2004; and Green, 2000).

This article has reported an empirical study of public health educators' participation in teams. The health educators surveyed were active in teamwork, primarily outside their organization. Many served leadership roles; all were potential ambassadors for their organizations. In the future, it will be important to do a national comparison study of health educators to increase the likelihood that findings will influence professional preparation programs and national organizations to institute actions for building effective teamwork skills among their constituents. Future research should focus on a more finely grained analysis of the collaborations in which public health educators engage, the skills and knowledge needed for collaboration, the professional development needs of professionals on these teams, and the benefits and costs such collaboration brings to the workplace and to the community's health.

References

Baker, E. L., Jr., Potter, M. A., Jones, D. L., Mercer, S. L., Cioffi, J. P., Green, L. W., et al. (2005). The public health infrastructure and our nation's health. *Annual Review of Public Health*, *26*, 303-318.

Bakes-Martin, R., Corso, L. C., Landrum, L. B., Fischer, V. S., & Halverson, P. K. (2005). Developing national performance standards for local public health systems. *Journal of Public Health Management and Practice*, *11*(5), 418-421.

Berkowitz, B. (2001). Studying the outcomes of community-based coalitions. *American Journal of Community Psychology*, *29*(2), 213-227.

Butterfoss, F. D., Kelly, C., & Taylor-Fishwick, J. (2005). Health planning that magnifies the community's voice: Allies against asthma. *Health Education & Behavior*, *32*(1), 113-128.

Butterfoss, F. D., Morrow, A. L., Rosenthal, J., Dini, E., Crews, R., Clinton, R. C., et al. (1998). CINCH: An urban coalition for empowerment and action. *Health Education & Behavior*, *25*(2), 212-225.

CDC/ATSDR Committee on Community Engagement. (1997). *Principles of community engagement.* Atlanta, GA: Centers for Disease Control and Prevention Public Health Practice Program Office.

Chavis, D. M. (2001). The paradoxes and promises of community coalitions. *American Journal of Community Psychology*, *29*(2), 309-320.

Clark, N. M., Doctor, L. J., Friedman, A. R., Lachance, L. L., Houle, C. R., Geng, X., et al. (2006). Community coalitions to control chronic disease: Allies against asthma as a model and case study. *Health Promotion Practice, 7*(Suppl. 2), 14S-22S.

Cleary, H. P. (1995). *The credentialing of health educators: An historical account 1970-1990.* Allentown, PA: National Commission for Health Education Credentialing.

Dillman, D. A. (2000). *Mail and Internet surveys: The tailored design method.* New York: Wiley.

El Ansari, W., & Phillips, C. J. (2004). The costs and benefits to participants in community partnerships: A paradox? *Health Promotion Practice*, *5*(1), 35-48.

Fawcett, S. B., Lewis, R. K., Paine-Andrews, A. L., Francisco, V. T., Richter, K. P., Williams, E. L., et al. (1997). Evaluating community coalitions for the prevention of substance abuse: The case of Project Freedom. *Health Education & Behavior, 24*(6), 812-828.

Francisco, V. T., Fawcett, S. B., Schultz, J. A., Berkowitz, B., Wolff, T. J., & Nagy, G. (2001). Using Internet-based resources to build community capacity: The community tool box. *American Journal of Community Psychology*, *29*(2), 293-301.

Freudenberg, N., & Golub, M. (1987). Health education, public policy, and disease prevention: A case history of the New York City coalition to end lead poisoning. *Health Education Quarterly, 14*(4), 387-401.

Gilmore, G. D., Olsen, L. K., Taub, A., & Connell D. (2005). Overview of the National Health Educator Competencies Update Project, 1998-2004. *Health Education & Behavior*, *32*(6), 725-737.

Green, L. (1984). Health education models. In J. D. Matarazzo (Ed.), *Behavioral health: A handbook of health enhancement and disease prevention*. New York: Wiley.

Green, L. W. (2000). Caveats on coalitions: In praise of partnerships. *Health Promotion Practice, 1*(1), 64-65.

Institute of Medicine. (1988). *The future of public health*. Washington, DC: National Academies Press.

Institute of Medicine. (2003). *The future of the public's health in the 21st Century*: Washington, DC: National Academies Press.

Kegler, M. C., Steckler, A., McLeroy, K., & Malek, S. H. (1998). Factors that contribute to effective community health promotion coalitions: A study of 10 Project ASSIST coalitions in North Carolina. *Health Education & Behavior*, *25*(3), 338-354.

Kuhn, M., Doucett, C., & Edwards, N. (1999). Effectiveness of coalitions in heart health promotion, tobacco use reduction, and injury prevention: A systematic review of the literature 1990-1998 (CHRU Publication No. DP99-1). Ottawa, Canada: Community Health Research Unit.

Lenaway, D., Halverson, P., Sotnikov, S., Tilson, H., Corso, L., & Millington, W. (2006). Public health systems research: Setting a national agenda. *American Journal of Public Health*, *96,* 410-413.

Mattessich, P. W., Murray-Close, M., & Monsey, B. R. (2004). *Collaboration: What makes it work: A review of research literature on factors influencing successful collaboration* (2nd ed.). St. Paul, MN: Wilder.

McKnight, J. (1995). *The careless society: Community and its counterfeits*. New York: Basic Books.

Mintzberg, H., Dougherty, D., Jorgensen, J., & Westley, F. (1996). Some surprising things about collaboration: Knowing how people connect makes it work better. *Organizational Dynamics*, *25*, 60-71.

National Commission for Health Education Credentialing. (2006). *A competency based framework for health educators.* Allentown, PA: Author.

Norris, T., & Pittman, M. (2000). The Healthy Communities Movement and the Coalition for Healthier Cities and Communities. *Public Health Reports*, *115*(2-3), 118-125.

Society for Public Health Education. (2005). *Tools of the trade*. Washington, DC: Author.

Wolff, T. (2001). The future of community coalition building. *American Journal of Community Psychology*, *29*(2), 263-269.

Wolff, T. (2003). The healthy communities movement: A time for transformation. *National Civic Review*, *92*(2), 95-111.