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Health Education Specialist Practice Analysis II 2020: Processes and Outcomes

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Abstract

Introduction.—The Health Education Specialist Practice Analysis II 2020 (HESPA II 2020) described the contemporary practice of health education specialists across work settings at entry and advanced levels. The purpose of the HESPA II 2020 manuscript was to report the research process and resulting data associated with the HESPA II 2020 and to provide recommendations for future practice analyses in health education.

Method.—Two data collection instruments were developed with the assistance of a 17-member Health Education Practice Panel to survey practicing health education specialists on the knowledge and skills needed in their ongoing roles. The instruments were designed to assess the degree to which the elements of the model had importance to practice (*Importance*), how often health education specialists performed the elements of the model (*Frequency*), and the point in time that health education specialists were expected to perform the various elements of the model (*Performance Expectation*). Composite scores for Sub-Competencies were calculated and subgroup comparisons were conducted to distinguish between levels of practice.

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Authors' Note

The institutional review Board at the University of Alabama approved the study protocol.

Declaration of Conflicting Interests

The authors declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: Ms. Lysoby and Ms. Kusorgbor-Narh are employed by the National Commission for Health Education Credentialing. Ms. Auld is employed by the Society for Public Health Education.

Results.—A total of 3,851 health education specialists provided usable responses. The final validated hierarchical model included eight Areas of Responsibility, 35 Competencies, and 193 Sub-Competencies. Of the Sub-Competencies, 114 were Entry level, 59 Advanced 1 level, and 20 Advanced 2 level. In addition, 145 knowledge items were verified.

Discussion.—HESPA II 2020 produced a validated hierarchical model descriptive of current practice of health education specialists across work settings. The results have implications for professional preparation, professional development, and certification.

Keywords

certification; competencies; credentialing; health education/promotion; health education specialist; job analysis; knowledge; practice analysis; professional preparation; workforce development

The Health Education Specialist Practice Analysis (HESPA) II 2020 is the latest practice analysis designed to advance the health education specialist profession. Practice analyses provide a means for the profession to adhere to one of the core principles of the National Task Force on Accreditation in Health Education by “assuring quality in professional preparation programs” (Allegrante et al., 2004, p. 676). Conducted at 5-year intervals, recurring practice analyses help satisfy standards under which the National Commission for Health Education Credentialing (NCHEC), the credentialing organization for health education specialists, is accredited. This time frame is also in tandem with other health care profession credentialing organizations (National Commission for Certifying Agencies [NCCA], 2016). Periodic practice analyses are important to ensure the contemporary research and practice of health education specialists, as a foundation for certification, and as a basis for quality assurance by employers and other stakeholders in the reimbursement of health education services.

The overarching goal of HESPA II 2020 was to assure that qualified health education specialists have the knowledge and skills to educate and improve the health of the public. The HESPA II 2020 study was guided by the principle that “health education is a single profession, with common roles and responsibilities” (Allegrante et al., 2004, p. 676). The processes followed in HESPA II 2020 were built on previous practice analyses: (1) the Role Delineation Project (Cleary, 1995), (2) Competencies Update Project (CUP; Gilmore et al., 2005), (3) Health Education Job Analysis (HEJA) 2010 (Doyle et al., 2012), and (4) HESPA I 2015 (McKenzie et al., 2016).

The Role Delineation Project (Cleary, 1995; NCHEC, 1985), initiated in 1978, was the first study to identify generic skills for health education specialists across work settings. The results defined the emerging profession and provided the initial framework for modern-day practice. This process also brought about other advancements characteristic of a maturing profession, for example, a code of ethics and the credentialing of programs and individuals (Allegrante et al., 2004; Coalition of National Health Education Organizations [CNHEO], n.d.; Cottrell et al., 2012; Taub et al., 2014). The CUP (Gilmore et al., 2005) resulted in the first hierarchical model for health educators including Entry Level, Advanced 1– and Advanced 2–Level Sub-Competencies, differentiated by years of experience and educational degree. The HEJA 2010 (Doyle et al., 2012) revalidated and further refined the hierarchical

model. The HESPA I 2015 (McKenzie et al., 2016) introduced a terminology change from “health educator” to “health education specialist” and changed the title from “job analysis” to “practice analysis” to better reflect the contemporary nature of the profession. HESPA II 2020, cosponsored by the NCHEC and the Society for Public Health Education (SOPHE), represents the fourth practice analysis since the Role Delineation Project (Doyle et al., 2012; Gilmore et al., 2005; McKenzie et al., 2016). HESPA II 2020 was implemented to understand the skills and knowledge needed for health education specialists to effectively function in their roles.

The HESPA II 2020 practice analysis included two major phases: (1) an instrument development phase and (2) a validation study phase. Both phases were intended to address the following research questions:

Research Question 1: What are the Areas of Responsibility (Responsibilities), Competencies, and Sub-Competencies in the practice of entry-level health education specialists?

Research Question 2: What are the Responsibilities, Competencies, and Sub-Competencies in the practice of advanced-level health education specialists?

Research Question 3: What baseline Knowledge is required to perform the Responsibilities, Competencies, and Sub-Competencies for health education specialists?

The purpose of the HESPA II 2020 manuscript was to report the research process and resulting data associated with the study research questions. Furthermore, the paper sought to provide recommendations for future practice analyses in health education. Although beyond the scope of the current paper, the results of HESPA II 2020 will provide relevant information to update the CHES (Certified Health Education Specialist) and MCHES (Master Certified Health Education Specialist) examinations and help inform health education professional preparation programs at the baccalaureate, master’s, and doctoral levels, as well as continuing education offerings.

Method

HESPA II 2020 employed qualitative and quantitative methods that align with credentialing industry standards and guidelines, that is, the NCCA (2016; Institute for Credentialing Excellence, 2014, and revised in 2016), *Uniform Guidelines on Employee Selection Procedures* (U.S. Equal Opportunity Employment Commission, 1978), *Standards for Educational and Psychological Testing* (American Educational Research Association et al., 2014), and the *ISO/IEC 17024* (International Organization for Standardization/ International Electrotechnical Commission, 2012). A steering committee referred to as the Technical Advisory Group (TAG) led the 22 month-study. TAG members included the chief executive officers of NCHEC and SOPHE, the coordinator for NCHEC’s Division Board for Certification of health education specialists, a cochair of the HESPA I 2015 Steering Committee, and cochairs appointed by NCHEC and SOPHE. Scantron, experts in certification, provided technical oversight of the project. The institutional review board at the University of Alabama approved the study protocol.

Participants

Study volunteers included (1) health education specialists assisting with instrument development and (2) survey respondents to one of two online instruments.

Instrument Development Volunteers.—A Health Education Practice Panel (HEPP) was formed to discuss current and emerging Responsibilities, Competencies, and Sub-Competencies, as well as knowledge areas, for health education specialists. SOPHE and NCHEC sought volunteers for the HEPP through professional national and state/local health education listservs, other health-related organizations, and communiqués to individuals with past contact with the organizations. Recruitment also occurred through nominations by the CNHEO member organizations. From the pool of 143 volunteers, the TAG selected a 17-member HEPP representing important diversity and other demographic factors to the health education profession. The HEPP members attended three in-person meetings between May and July 2018. Their work became the basis for the HESPA II 2020 validation and knowledge surveys.

Survey Respondents.—Two inclusion criteria were required for participation in the HESPA II 2020 validation instruments: (1) self-identification as a health education specialist (certified and noncertified) and (2) health education practice in any work setting within the past 12 months. For the purposes of this study, a health education specialist was defined as follows:

An individual who has met, at a minimum, baccalaureate-level required health education academic preparation qualifications, who [could serve] in a variety of settings, and is able to use appropriate educational strategies and methods to facilitate the development of policies, procedures, interventions, and systems conducive to the health of individuals, groups, and communities. (Joint Committee on Health Education and Promotion Terminology, 2012, p. 12)

Survey respondents received one of two online instruments. Two separate survey instruments were developed to minimize fatigue from completing a single, lengthier survey. Instrument 1 was used to validate the identified (1a) Responsibilities, (1b) Competencies, and (1c) Sub-Competencies. Instrument 2 was used to validate the identified (2a) Responsibilities and (2b) Knowledge statements. Both instruments contained the same introduction, screening question to determine eligibility, and demographic and professional questions. Respondents were randomly routed to either Instrument 1 (80%) or Instrument 2 (20%), to approximate a 4:1 assignment ratio. A larger percentage was routed to Instrument 1 to ensure adequate statistical power for determining test specifications for the CHES and MCHES examinations. Given the nature of the Competencies and Sub-Competencies and their usefulness in preparing health education specialists for research and practice, this ratio has been applied since the HEJA practice analysis study (Doyle et al., 2012). As the Sub-Competencies are used to write CHES/MCHES exam items, an adequate sample size for testing model validity is especially critical. Information relating to the composition and recruitment of all study participants follows.

Survey Recruitment

To reach a broad cross section of health education specialists, NCHEC and SOPHE staff identified some 200 contacts at health education organizations, including CNHEO member organizations and national and state public health/health education organizations/associations. Each contact received a personal communication requesting organizational assistance with publicity and dissemination of survey-related information to its members. Organizations used electronic communications to provide a survey link. They promoted participation through announcements at various meetings, newsletters, listservs, and social media.

Survey invitations were also e-mailed to national and chapter SOPHE members ($N \sim 3,500$) and individuals holding CHES/MCHES certification ($N = 13,271$). Strategies for recruiting invited nonresponders included (1) sending e-mail and postcard reminders, (2) extending survey completion deadline, (3) awarding one Continuing Education Contact Hour to NCHEC-certified individuals for survey completion, and (4) offering voluntary enrollment in a drawing to receive one of 20 US\$50.00 Amazon gift cards.

Survey Instrument Development

The HEPP made several recommendations regarding contemporary health education specialist practice to the TAG and Castle/Scantron during the summer 2018 in-person meetings. The HEPP recommendations resulted in eight Responsibilities. The first recommendation was to separate the HESPA I 2015 Responsibility *Communicate, Promote, and Advocate for Health, Health Education, and the Profession* into two separate Areas: (1) *Communication*, prompted by the rapid expansion of communication strategies and technology, and (2) *Advocacy*, acknowledging its increased emphasis to effectively address the socioecologic factors affecting the health of individuals, communities, and populations. The second HEPP recommendation was to add *Ethics and Professionalism* as a Responsibility, reflecting its importance in all aspects of health education practice. This resulted in the removal of the HESPA I 2015 Responsibility VI *Serve as a Health Education/Promotion Resource Person*, as many of its Competencies and Sub-Competencies were assumed in this newly recommended Responsibility. The remaining Sub-Competencies from the Resource Person Responsibility were redistributed to *Leadership and Management* and *Communication*.

The TAG decided the first four Responsibilities on the survey instrument should be *Assessment of Needs and Capacity, Planning, Implementation, and Evaluation & Research* to be consistent with previous practice analyses, followed by *Advocacy, Communication, and Leadership & Management*. The new Responsibility, *Ethics and Professionalism*, was positioned last due to its overarching nature and foundation in practice. The HEPP determined the HESPA I 2015 number of Sub-Competencies was high ($n = 258$) and recommended the synthesis of these statements. Applying precedence and professional judgment, the HEPP developed a preliminary hierarchical model comprising 35 Competencies, 193 Sub-Competencies, and 149 Knowledge statements.

Both instruments were uploaded on a survey driver, programmed in Cold Fusion Version 9.0. The instruments used 4-point, Likert-type scales to assess the degree to which the elements of the proposed model had importance to practice (*Importance*), how often health education specialists performed the elements of the model (*Frequency*), and the point in time that health education specialists were first expected to perform the various elements of the model (*Performance Expectation*; see Table 1). Participants evaluated the statements in the context of their own practice as a health education specialist. The scales were modified slightly to evaluate the statements in the Knowledge survey. After each series of statements, an empty field was provided to solicit open-ended feedback. Pilot testing was conducted between October 2, 2018, and October 15, 2018. Participation in the pilot resulted in 13 completed and usable surveys, which were reviewed by the TAG, leading to the final two surveys for implementation in the study.

Data Collection

Data for the full-scale study were collected over a 12-week period from November 5, 2018, to January 31, 2019. Given the scope of the study and general nature of survey research, some level of incomplete data was assumed, and thus a procedure for determining retention of response records for analysis was developed. The TAG decided that instrument data would be divided into two groups: (1) respondents who provided complete ratings and (2) respondents who provided incomplete ratings. Next, a principal components analysis determined if the ratings provided by the two groups were homogeneous, or if there was a point of completion that could be identified as a threshold to eliminate responses. Eigenvalue threshold for group comparison was set a priori at 1.0.

Data Analysis

All data for HESPA II 2020 were analyzed using SAS software, Version 9.4, of the SAS System for Windows.

Survey Validity and Reliability

Content validity for both surveys was evaluated through an eight-step process (see Table 2). Reliability of the surveys was assessed with coefficient alphas calculated for each Competency and Sub-Competency as they were categorized into Responsibilities. Similarly, alpha coefficients were calculated for the Knowledge statements.

Validation of Responsibilities.—Besides demographic data, Responsibilities data were combined from Instruments 1 and 2. Respondents were asked to provide ratings for each proposed Responsibility using the *Importance*, *Frequency*, and *Performance Expectation* scales. Final classification and ordering of the Responsibilities were confirmed by the TAG.

Validation of Hierarchical Model.—For the purpose of the practice analysis, a Responsibility, Competency, Sub-Competency, or Knowledge statement was included in the model if (1) the HEPP reached consensus that the component should be included in the proposed model with the language given and (2) the ratings collected in the instruments were sufficient to support the statement's relevance to practice, that is, instrument validation. In addition to *Importance*, *Frequency*, and *Performance Expectation* descriptive statistics,

composite scores were calculated for each Responsibility, Competency, Sub-Competency, and Knowledge statement using the same formula applied in HESPA I 2015 (McKenzie et al., 2016):

$$\text{Composite Score} = \text{Importance} + (\text{Frequency} - 1).$$

A threshold composite score of 3.0, also used in HESPA I 2015 (McKenzie et al., 2016), determined which elements of the hierarchical model should be retained and which should be eliminated. To support these decisions, a Rasch analysis was conducted for each Responsibility, Competency, and Sub-Competency. Additionally, a discriminant function analysis was performed based on respondent experience and education. Analysis of variance (ANOVA) models comparing means for experience and education classifications for each rating scale were also calculated.

Validation of Entry- and Advanced-Level Sub-Competencies.—Respondents were grouped by years of experience: 0 through 4 years of experience; and 5+ years of experience (see Table 3). This threshold was chosen because it aligns with MCHES certification eligibility. Using the composite scores for each respondent, two-sided *t* tests were calculated for each Sub-Competency using alpha .05 for the two groups. The ANOVA models determined whether there was a directionally and statistically significant difference in responses based on experience for each Sub-Competency. If a difference was identified, the Sub-Competency was classified as advanced; otherwise, it was classified as entry level. Final classifications of entry- and advanced-level Sub-Competencies were confirmed by the TAG.

Validation of Advanced 1– and 2–Level Sub-Competencies and Knowledge Statements.—Respondents were grouped according to their highest degree earned in health education. The first group contained respondents reporting a bachelor’s degree, while the second group included respondents reporting a master’s degree or higher (see Table 4). Using the composite scores, two-sided *t* tests were calculated using an alpha .05 for the two education groups. Aided by the composite score classifications, final classifications of Advanced 1– and 2–Level Sub-Competencies were confirmed by the TAG. Using the same composite score formula and threshold, Knowledge statements were also assessed for validity.

Results

Participation

Given there is no centralized data base of all HES, an exact response rate for HESPA II 2020 was impossible to calculate. The response rate of the group of individuals with CHES or MCHES certification was 16.2%. Relative to most practice analysis studies, this level of participation is acceptable (Myers et al., 2019, p. 256). Demographic findings of HESPA II 2020 were similar to previous practice analysis surveys in health education, suggesting survey representation was similar to the CUP (Gilmore et al., 2005), HEJA (Doyle et al., 2012), and HESPA I 2015 studies (McKenzie et al., 2016).

Preparatory Analyses, Survey Completion, and Reliability

Following collection, the data were cleaned and analyzed to identify anomalies, eliminate duplicate entries, and evaluate completeness. A total of 33 respondents completed their assigned survey more than once. Using the respondents' traceable identification number, the duplicate survey that was most complete was retained. In cases in which all duplicates were equally complete, the duplicate with the earlier time stamp was retained. Principal components analysis indicated homogeneity between the group of respondents that provided complete data (702 ratings in the Instrument 1; 320 ratings in Instrument 2), compared to the group of respondents that did not provide complete data in Instrument 1 ($n = 2,378$) or Instrument 2 ($n = 451$). An ANOVA determined there was no significant difference in ratings provided by the groups, for either Instrument 1, $F(1, 46) = 1.6, p = .21$, or Instrument 2 $F(1, 46) = 0.3, p = .61$; therefore, ratings provided by all respondents were analyzed. The final data sets included 3,080 Instrument 1 (Responsibilities, Competencies, and Sub-Competencies) respondents and 771 Instrument 2 (Responsibilities and Knowledge) respondents, for a total of 3,851 respondents. In terms of reliability, coefficient alphas for both surveys ranged from .89 to .98 and were considered reliable.

Survey Participant Demographics

Respondents were found in all 50 states, the District of Columbia, and Puerto Rico; 23 respondents worked outside the United States. The greatest portion of respondents were from California (10.0%, $n = 198$), Texas (6.2%, $n = 123$), and New York (5.3%, $n = 105$). Participants were primarily female (88.3%, $n = 1,774$), White/European (75.5%, $n = 1,493$), and between 26 and 35 years of age (41.1%, $n = 827$). Table 4 summarizes participant demographic data. These demographics mirror the U.S. Department of Labor statistics on location of health educators by state (U.S. Department of Labor, Bureau of Labor Statistics, 2018).

Survey Participant Professional Data

Most participants worked full-time (80.6%, $n = 1,616$) as a health education specialist, completed a master's degree (60.9%, $n = 1,223$), and held the CHES credential (78.8%, $n = 1,584$). Nearly one third of respondents (30.9%) had 0 to 4 years of experience as health education specialist; those with 5 to 9 years represented 24.3% of participants. The greatest percentage of participants identified their work setting as public health agency (22.9%, $n = 461$), followed by health care (18.0%, $n = 361$), academia (17.3%, $n = 348$), community (16.7%, $n = 336$), business/worksites (8.3%, $n = 167$), college health (5.5%, $n = 110$), school health, (4.1%, $n = 82$), and other (6.6%, $n = 132$). Table 3 summarizes participant professional data.

Validity of Responsibilities

The number of respondents for the Responsibility items ranged between 3,713 and 3,794, as respondents did not all give complete responses. Mean ratings for *Importance* ranged from 3.0 (*moderately important*) to 3.8 (*approaching highly important*). Mean ratings for *Frequency* ranged from 2.4 (*between occasionally and frequently*) to 3.6 (*between frequently and very frequently*). The *Performance Expectations* ratings ranged from 1.1 (*in*

Year 1) to 1.7 (in Year 1 but approaching Year 2). All eight Responsibilities were validated (see Table 5).

Validity of Competencies, Sub-Competencies, and Knowledge Statements

Applying the composite score threshold of 3.0, all Competencies and Sub-Competencies were retained. However, a total of four Knowledge statements were eliminated. The final validated hierarchical model based on HESPA II 2020 included 35 Competencies, 193 Sub-Competencies, and 145 Knowledge Statements.

Applying the validation process, 114 Sub-Competencies were classified as entry level and 79 were classified as advanced level. Those Sub-Competencies classified as advanced level were further categorized as Advanced 1 level ($n = 59$) and Advanced 2 level ($n = 20$) using previous classifications at this level and the expert judgment of TAG members. Table 5 summarizes the final ordering of the Responsibilities as well as the number of Competencies and Sub-Competencies at each level. Mean *Importance* ratings, mean *Frequency* ratings, and composite scores for the eight Responsibilities are included.

Discussion

The HESPA II 2020 sought to describe the contemporary practice of HES across work settings at entry and advanced levels and to validate the Responsibilities, Competencies, and Sub-Competencies required at both practice levels. The final hierarchical model consisted of eight Responsibilities, 35 Competencies, and 193 Sub-Competencies. Of the 193 Sub-Competencies, 59.0% ($n = 114$) were identified as Entry level, 30.5% ($n = 59$) Advanced 1 level, and 10.36% ($n = 20$) Advanced 2 Level. A total of 145 knowledge items were also verified as part of HESPA II 2020.

Perhaps the most significant change relative to previous models was the addition of an eighth Responsibility: Ethics and Professionalism. In previous iterations, the Competencies and Sub-Competencies for Ethics and Professionalism were integrated throughout the various Responsibilities. However, the TAG and HEPP determined the overarching influence of ethics and professionalism on the health education practice required these two domains should be designated its own Responsibility. HESPA 2015 Responsibility *Communicate, Promote, and Advocate for Health, Health Education, and the Profession* was validated as two distinct Responsibilities—(1) *Advocacy* and (2) *Communication*—reflecting increasing practice responsibilities and competency required in both areas.

Another important outcome of HESPA II 2020 was the reduction in the number of Sub-Competencies from HESPA I 2015 to HESPA II 2020. To increase the utility of the framework, the panel sought to eliminate the redundancy of Sub-Competencies within the HESPA I 2015 (e.g., ethical principles, cultural inclusion/humility). One example was a single HESPA II 2020 Sub-Competency (Area VIII: *Ethics and Professionalism*: 8.1.3.), which was consolidated from eight HESPA I 2015 Sub-Competencies (Area II: 2.3.12; Area III: 3.1.6; 3.4.7; Area IV: 4.4.5; Area V: 5.5.9; 5.6.3; Area VII: 7.2.4; 7.2.8). Overall, the number of Sub-Competencies was reduced by 25.19% in HESPA II 2020, from 258 Sub-Competencies validated in HESPA I 2015 to 193 Sub-Competencies validated in HESPA II

2020. This translated to a reduction in the number of entry-level Sub-Competencies from 141 in HESPA I 2015 to 114 in HESPA II 2020; a 19.14% decrease. This further led to a reduction in Advanced 1– and Advanced 2–level Sub-Competencies, from 76 and 41 in HESPA I 2015 to 59 and 20 in HESPA II 2020, respectively. While the total number of Sub-Competencies was reduced, the number of Competencies only decreased by one, from 36 to 35. This finding also suggests the general practice requirements of HES remained rather stable across the HESPA I 2015 and HESPA II 2020.

Differences in Sub-Competencies did emerge in the preparation of the HESPA II 2020 survey instrument. The concept of systems thinking/change was included in the HESPA II 2020 as an emerging trend. Also highlighted were additional facilitation skills for coordinating efforts in the delivery of health education and promotion through various health communication and technology channels. Coalitions, networking, health/media literacy, and public speaking as health education/promotion strategies were augmented under various Competencies. Last, the expansion of logic models and the application of socioecologic models in planning and evaluation were included as an established trend in the health education/promotion.

Limitations of the Study

The HESPA II 2020 study had several limitations. Not all individuals meeting the definition of a health education specialist could be recruited or agreed to participate. Although a rigorous recruitment process was implemented, a complete sampling frame of health education specialists remains elusive. Recruitment of individuals working in the profession who are not credentialed (e.g., CHES/MCHES), do not belong to any professional associations (e.g., SOPHE), and are not enrolled in any professional listservs (e.g., HEDIR) were particularly difficult to reach. Although attempts were made to increase participation among credentialed health education specialists, only 16.2% of those with a CHES or an MCHES certification participated. Health education specialists working in K–12 school settings were the most difficult to reach. This was also noted as a limitation in HESPA I 2015 (McKenzie et al., 2016). Given the requirement of school health education specialists to become licensed, they may have associated HESPA II 2020 with the CHES/MCHES examinations and deemed their participation irrelevant. In addition, school health education licensure requirements are inconsistent from state to state. This, along with not being able to identify specific individuals, makes it difficult to identify qualified health education specialists working in school settings and to access a sampling frame of this population. Another issue is that in recent years there has been a decline in employment of professionally prepared health education specialists in schools as well as professional health education preparation programs in school settings (Birch et al., 2019; Mann & Lohrmann, 2019). Some schools may assign teaching health education to other professionals (e.g., physical educators), which would prevent them from moving past the gating question for study participation.

HESPA II 2020 was vulnerable to limitations inherent to online survey research including potential firewalls/spam blocking software, lower response rates, possible participant computer malfunctions, participant failure to understand survey instructions (e.g., not

clicking hyperlink, accidentally clicking past pages of the survey), and accidental deletion of survey-related emails. Other potential issues such as less time available to participate due to administrative responsibilities or a perception that the study did not align with current job responsibilities may help, in part, to explain the reason why such a large percentage (49.7%) of respondents were 25 years old or younger. Data collection instrument length was addressed by dividing the initial instrument into two separate survey instruments. Even more, the instrument length may have been responsible for missing demographic data. For example, only 2,008 of 3,851 eligible participants completed demographic data requesting highest degree of education obtained with a major emphasis on health education. Given the usefulness of years of experience and highest level of education for classification of Competencies and Sub-Competencies, it is recommended that future analyses include the demographic items early in the survey to increase response rate.

The sample used in the study is in tandem with previous iterations and is considered generally reliable from a credentialing perspective (Myers et al., 2019). The HESPA II sample was predominantly female, which reflects the demographic characteristics of the profession. Approximately 84% of SOPHE membership (SOPHE, 2020) and 90% of CHES or MCHES credential holders (NCHEC, 2020) are women. The sample is also consistent with the HESPA I sample, which was composed of 89.4% females (McKenzie et al., 2016). Therefore, it appears the ratio of men to women collected for HESPA II is representative of the profession.

Implications for Practice

Although the differences between HESPA I 2015 and HESPA II 2020 were not of major significance, professional preparation and continuing education providers will need to update their offerings to address the afore-referenced changes in knowledge or skills needed. For example, in the area of advocacy, entry-level health education specialists will be expected to identify factors that facilitate and/or hinder advocacy efforts and identify existing coalitions and stakeholders that favor and oppose the proposed policy, system, or environmental change and their reasons. NCHEC and SOPHE are assisting providers to adjust their training by providing various publications, webinars, workshops, and other communication to the field.

Postsecondary educational programs and those responsible for professional development in health education can use the validated hierarchical model and the knowledge outline to assist in developing content that will translate from the classroom to practice in the field. The hierarchical model also serves as a schema of practice and content for the CHES and MCHES certification examinations. With the increased movement toward reimbursement for wellness and counseling services, public and private insurers are looking for quality measures for rendered services, which is typically reflected in licensure or certification such as CHES/MCHES certification.

Recommendations for future practice analyses include the following:

1. Reverifying the Responsibilities and Competencies at 5-year intervals is critical to the profession. The outcomes serve to define the contemporary practice of health education.
2. Planning for further job analysis studies should begin at least 24 months in advance of the expected release date. Future TAG and HEPP members should at a minimum review previous practice analysis technical reports, meeting minutes, and publications related to the analyses.
3. Contracting with practice analysis specialists should be considered a standard of practice to ensure timely completion and use of most current methodologies.
4. Strategies should be explored to expand survey recruitment. Increased awareness of HESPA II 2020 and future iterations should be promoted frequently in professional settings, for example, professional conferences.
5. When developing instruments for future practice analysis studies, researchers should consider placement of demographic questions; the numbers and types of questions for each Responsibility, Competency and Sub-Competency; and other factors that may influence survey completion.

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Table 1.

Rating Scales for Data Collection Survey Instruments.

Rating	Importance	Rating	Frequency	Rating	Performance expectation
1	Not important	1	Not at all	0	Never
2	Minimally important	2	Occasionally (less than once a month)	1	Year 1
3	Moderately important	3	Frequently (at least once per month)	2	Year 2 through Year 5
4	Highly important	4	Very frequently (at least once per week)	3	After Year 5

Table 2.

Steps Used to Create the Valid Data Collection Survey Instruments.

Step	Dates	Tasks
1. Develop and refine Areas of Responsibility, Competencies, and Sub-Competencies	May–July 2018	Three in- person meetings with 17 volunteer Health Education Practice Panel and TAG
2. Sampling plan development	May–July 2018	Development of a sampling plan for the validation survey by Castle/Scantron and outreach to the profession for volunteer survey
3. Creation of survey	July–October, 2018	TAG and Scantron via email and conference calls
4. Institutional review board approval	September 2018; revised based on pilot November 2018; revised for postcard January 2019, extension August 2019	Approval of the study by the Institutional Review Board of the University of Alabama
5. Survey pilot	October 2018	Pilot testing of the online survey for comprehensiveness, clarity, time to completion, and technical ease of use
6. Participant sampling	November 2018–January 2019	Email invitations to participate in the survey sent to a valid sample of 13, 271 health education specialists followed by periodic email and postcard reminders sent throughout a 3-month completion window resulting in 3,832 responses and a 16.2% response rate
7. Data analysis	February–July 2019	(a) Scantron conducted a series of statistical analyses of the survey results, (b) TAG Conference calls series, (c) Scantron and TAG meet in person April 23–24, 2019
8. Model finalization	August 2019	Technical Report from Scantron; acceptance of report by SOPHE and NCHEC boards

Note. TAG = Technical Advisory Group; SOPHE = Society for Public Health Education; NCHEC = National Commission for Health Education Credentialing.

Table 3.

Professional Data of Survey Participants.

Characteristics	<i>n</i> ^a	%
1. NCHEC certification status		
CHES	1,584	78.8
MCHES	335	16.7
No, never held either CHES or MCHES	80	4.0
No, lapsed CHES or MCHES	12	0.6
Total	2011	100.0
2. Years of experience as health education specialist		
0–4	607	30.9
5–9	477	24.3
10–14	284	14.4
15–19	209	10.6
20–24	174	8.9
25–29	86	4.4
30–34	72	3.7
35–39	47	2.4
40+	10	0.5
Total	1,966	100.0
3. Years in current position		
0–4	1,321	66.1
5–9 years	339	17.0
10–14	157	7.9
15–19	85	4.3
20–24	52	2.6
25–29	21	1.1
30–34	17	0.9
35–39	5	0.3
40+	2	0.1
Total	1,999	100.0

Note. NCHEC = National Commission for Health Education Credentialing; CHES = Certified Health Education Specialist; MCHES = Master Certified Health Education Specialist.

^aTotal n varies based on participant responses.

Table 4.

Demographic Data of Survey Participants.

Characteristics	<i>n</i> ^a	%
1. Gender		
Female	1,774	88.3
Male	210	10.5
Other	3	0.1
Prefer not to answer	21	1.0
Total	2,008	100.0
2. Ethnicity: Hispanic, Latino, or Spanish origin No, not of Hispanic, Latino, or Spanish origin		
Yes, Mexican, Mexican American, or Chicano	92	4.6
Yes, Puerto Rican	29	1.4
Yes, Cuban	8	0.4
Yes, another Hispanic, Latino, or Spanish Origin	61	3.0
Prefer not to answer	64	3.2
Total	2,007	100.0
3. Racial background		
White	1,493	75.5
Black or African American	289	14.6
American Indian or Alaska Native	24	1.2
Asian Indian	21	1.1
Japanese	10	0.5
Native Hawaiian	5	0.3
Chinese	24	1.2
Korean	8	0.4
Guamanian or Chamorro	1	0.1
Filipino	36	1.8
Vietnamese	4	0.2
Samoan	1	0.1
Other, Asian	16	0.8
Other, Pacific Islander	1	0.1
Some other race	44	2.2
Total	1,977	100.0
4. Age, years		
25	173	8.6
26–35	827	41.1
36–45	433	21.5
46–55	270	13.4
56–65	217	10.8
66–75	59	2.9
75 +	3	0.1

Characteristics	<i>n</i> ^a	%
Prefer not to answer	28	1.4
Total	2,010	100
5. Employment status		
Full-time (≥ 30 hours per week)	1,616	80.6
Part-time (<30 hours per week)	390	19.4
Total	2,006	100.0
6. Education (highest level of degree earned)		
Bachelor's	354	17.6
Some postbachelor's education	88	4.4
Some master's degree (e.g., MA, MS, MPH, MSPH, MHA, MEd)	1,223	60.9
Education specialist (EdS)	5	0.2
Doctorate (e.g., PhD, EdD, JD, MD, DrPH)	338	16.9
Total	2,008	100.0
7. Highest degree obtained that include major emphasis on health education		
Bachelor's	496	24.7
Master's degree other than MPH or MSPH	491	24.5
Master of Public Health (MPH)	698	34.8
Doctorate (other than Public Health)	171	8.5
Doctor of Public Health	89	4.4
Other	55	2.7
None	8	0.4
Total	2,008	100

^aTotal *n* varies based on participant responses.

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Table 5.

HESPA II 2020 Areas of Responsibility, Competencies, and Sub-Competencies at Each Level Along With Mean Importance Ratings, Mean Frequency Ratings, and Composite Scores for the Eight Areas of Responsibility.

Area of Responsibility	No. of Competencies	Total Sub-Competencies	Entry-level	Advanced 1 level	Advanced 2 level	n	Mean importance	Mean frequency	Composite score
I. Assessment of Needs and Capacity	4	25	22	3	0	3,794	3.6	2.9	5.5
II. Planning	4	19	11	8	0	3,771	3.7	3.3	6.0
III. Implementation	3	16	15	1	0	3,743	3.7	3.2	5.9
IV. Evaluation and Research	5	37	6	16	15	3,746	3.3	2.7	5.1
V. Advocacy	4	18	16	2	0	3,754	3.0	2.4	4.4
VI. Communication	6	26	24	1	1	3,752	3.8	3.6	6.4
VII. Leadership and Management	5	31	6	23	2	3,755	3.3	3.0	5.3
VII. Ethics and Professionalism	4	21	14	5	2	3,758	3.7	3.5	6.2
Total	35	193	114	59	20	—	—	—	—

Note. Importance scale: 1 = not important, 2 = minimally important, 3 = moderately important, 4 = highly important; Frequency scale: 1 = not at all, 2 = occasionally, 3 = frequently, 4 = very frequently. HESPA II 2020 = Health Education Specialist Practice Analysis II 2020.