Graduate Health Education Programs' Support for the NCHEC Competencies and the Graduate Standards

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Abstract

A survey was conducted to determine the level of support for the NCHEC Competencies, the CHES exam, and the SOPHE/AAHE Joint Graduate Standards. Responses from chairs and graduate program coordinators from three types of graduate community health education programs (schools of public health, MPH in Community Health Education programs, and other master-level programs) were obtained. Support was found for all of the above, with higher levels for the Graduate Standards.

Introduction

The field of health education has matured as a profession over the past twenty years. Historic milestones for this emerging profession include the 1983 release of "A Guide for the Development of Competency-Based Curricula for Entry-Level Health Educators," the 1985 release of the "Framework" document, and the establishment of the National Commission for Health Education Credentialing (NCHEC) in 1988 with its subsequent certification of health education specialists in 1989 (Cleary, 1997; Nolte & Hamburg, 1993; Taub 1998). The release of the NCHEC responsibilities and competencies for entry-level health educators was instrumental for the development of the credentialing of individuals in the profession (through the examination to become a Certified Health Education Specialist or CHES). The NCHEC responsibilities and competencies have also been used to guide curricular development efforts among professional preparation programs. O'Rourke, Schwartz, and Eddy (1997) found that of the 129 undergraduate professional preparation programs responding to their survey, 93% reported preparing students in the NCHEC entry-level competencies. The authors found that the NCHEC competencies had the greatest impact on: (a) the health education curricula, (b) the quality of students graduated from the programs, and (c) student employment prospects. They found that relatively few health education graduates (18%) were reported to have taken the NCHEC examination to become a CHES. The two quality assurance routes available for undergraduate health education degree programs include the National Council for the Accreditation of Teaching Education (NCATE) and Society for Public Health Education (SOPHE)/American Association for Health Education (AAHE) Baccalaureate Program Approval Committee (SABPAC). These programmatic accreditation/approval mechanisms utilize the NCHEC responsibilities and competencies as the basis for their review standards. The NCATE process was reviewed by Smith, Ames, Patterson, and Frazee (1999), and Brookins-Fisher and Pope (1999) reported on an examination of SABPAC-approved programs.

While these efforts have done much to promote quality, competency-based undergraduate education of health educators, until the past several years, little attention has been paid to graduate-level preparation of health educators. Graduate education in health education has a long history (Bensley, 1990), yet, in spite of several attempts over the past decades to standardize graduate study in the field, few graduate preparatory programs have sought to meet standardization or quality assurance requirements associated with programmatic accreditation. The exception, according to Bensley (1990), are those graduate programs accredited by the Council for Education in Public Health (CEPH). Approximately a dozen graduate degree programs in community health education have been CEPH accredited, along with 28 schools of public health, many of which offer health education specializations. These accredited programs are from among the 136 graduate-level programs in health education that are listed in the *American Association for Health Education's Directory of Institutions Offering Undergraduate and Graduate Degree Programs in Health Education* (1997),

suggesting a low level of acceptance for programmatic accreditation in the majority of health education graduate programs.

Bensley and Pope (1994) noted that the history of neglect for developing and using standards for graduate study in health education has resulted in a serious lack of standardization of requirements among graduate programs. In 1992 the Joint Committee for Graduate Standards was formed by several health education professional organizations including SOPHE and AAHE. In February of 1996, the resulting Joint Graduate Standards were presented to 138 representatives from 81 institutions with graduate health education programs at the "National Congress for Institutions Preparing Graduate Health Educators" (Joint Committee for Graduate Standards, 1997). The Joint Graduate Standards were formally released by SOPHE and AAHE in 1997 (Capwell, 1997). They added three new responsibilities to the original seven: research principles and methods, program administration, and advancement of the profession (Capwell, 1997; Dennison, 1997). Several new competencies and sub-competencies were added to the existing responsibilities for entry-level health educators as part of the broader graduate standards. According to Dennison:

> AAHE/SOPHE Joint Graduate Standards can be expected to stimulate future development of course work guidelines for graduate programs; integration of these standards into program accreditation; improved standardization of professional preparation programs; and, possible multiple levels of individual professional certification...As health educators, the implementation of these standards is a responsibility in advancing our profession (p. 68).

Elaine Auld (1996-1997), SOPHE's Executive Director, suggested that the development of the graduate competencies should advance the profession in several ways including: "encouraging graduate health education preparation programs to better prepare students to function as health education practitioners; defining for employers and other professionals the unique knowledge and skills of graduate-prepared health educators" (p. 4). The Joint Committee for the Development of Graduate Level Standards (1997) added that "the need for standards to guide professional preparation programs was the driving force for developing the responsibilities and competencies" (p. 6). The Joint Committee stated that the adoption of these graduate standards would assure a common core of preparation for practice upon which employers could rely regardless of the program from which the prospective employees graduate. This should help the profession become better recognized, thus increasing the marketability of program graduates. The Joint Committee stated its belief that as the standards are more widely adopted, the competencies would become part of the program accreditation review criteria.

The need for increasing the number of graduate health education programs pursuing programmatic accreditation was emphasized in a recent "White Paper" developed by The Johns Hopkins University School of Public Health and Hygiene, in collaboration with SOPHE for the Health Resources and Services Administration's Bureau of Health Professions (Merrill, Chen, Gielen, McDonald, Auld, Mulrooney, & Sampson, 1998). Future health education student demand for master-level preparation in health education and related issues, including accreditation at the graduate program level, were included in this study. One of the training recommendations was to: "Promote adoption of the graduate competencies by graduate health education training programs and identify other means to assure that such programs are preparing students adequately in the areas of particular relevance for the future" (p. S–63). The report also noted that CEPH has no requirement that either the NCHEC responsibilities and competencies for entry-level health educators or the Joint Graduate Standards be used by graduate programs, yet, the East Stroudsburg Master of Public Health (MPH) in Community Health Education program reported incorporating these in its graduate accreditation efforts (Livingood, Woodhouse, Underwood, Shive, & Waring, 1995).

Additionally, a high overall pass rate of master-level prepared graduates on the CHES exam was confirmed (94.55%) in a study of CHES pass rates conducted by Sciacca, Neiger, Poindester, Hubbard, Giles, Black, Barr, Middleton, Cosgrove, and Cleary (1999). This finding suggests that graduate health education programs are addressing at least the original NCHEC responsibilities and competencies.

The degree to which other graduate programs have adopted, or intend to adopt, the new Joint Graduate Standards is as of yet undetermined. The purposes of this study were to: (a) describe the characteristics of graduate-level community health education programs at the master's level, and (b) determine the level of support among those program chairs/graduate program coordinators responding to the survey for the NCHEC competencies, the CHES examination, and the Joint Graduate Standards. Its specific objectives were to:

1. Describe basic characteristics of the various types of graduate programs (at the master's level) in graduate-level community health education
2. Determine the level of support of the program chairs/graduate program coordinators of the three major types of graduate programs for the NCHEC responsibilities and for the CHES examination process.
3. Determine the level of support of the program chairs/graduate program coordinators from the three groups of graduate programs for: (a) the new AAHE/SOPHE Joint Graduate Standards, (b) NCHEC offering an advanced, graduate level CHES exam, (c) the accrediting bodies requiring academic programs to provide evidence on how they are covering the new graduate-level competencies, and (d) developing a new council or organization to represent their collective programmatic interests.

This survey was exclusively on graduate programs in community health education in order to maintain a focus on one common type of degree program and was not intended to include school health education or health promotion degree programs.

Methodology

In the fall of 1997 an initial survey was developed and refined though "face-to-face" interviews with the department chairs/heads of 12 CEPH accredited graduate programs in health education (only one was a school of public health). The investigator interviewed chairs from primarily MPH in community health education degree programs as these programs related best to the new MPH in community health education degree program from the author's home institution. Half of the interviews were conducted on-site in the programs' departmental offices, with the other half conducted during the American Public Health Association's national convention held in Indianapolis in November of 1997. Interview times ranged from an hour to more than two hours. Based upon the results of this effort, the questions were modified to ensure greater clarity and the number of survey items was reduced from its original seven pages of primarily open-ended questions, to a single page (front and back) with a total of 15 items. Three of these items used a 5-point Likert scale, seven were questions requiring only a yes or no response, two had multiple choices from which the respondent was directed to select all that applied, and one was an open-ended question. Analysis of nine of the original 15 items is reported in this manuscript. The two multiple choice items and the open-ended item were not used either. The decision to exclude these items was made by the author who deemed them to be irrelevant to the primary purposes of this study. A faculty/department profile section was also included with six questions. A cover letter introduced the study and the issues to be addressed (support for NCHEC competencies and adoption of new Joint Graduate Standards). The final survey and accompanying cover-letter were mailed out to the 106 graduate programs in community health education listed in the latest edition of the AAHE Directory (1997) at the end of November 1997. Surveys were color coded to determine to which group the program belonged, and a hand-written code number was entered in the lower right hand corner of each survey. Respondents were notified in the cover letter of this and were invited to clip the corner off to remove the number and ensure their program's confidentiality. Only two respondents did this. Responses continued to be received through January of 1998. A total of 34 surveys were mailed to schools of public health and MPH in Community/Preventive Medicine programs that, based upon their inclusion in the AAHE Directory, described offering a community health education degree. In addition, 17 surveys were mailed to MPH in Community Health Education programs. A total of 55 surveys were mailed to the remaining graduate programs that reported offering a degree in community health education.

Results

A total of 69 surveys were returned by the end of January, 1998, for a 65% overall return rate. No follow-up surveys or phone contacts were attempted. One of the 69 surveys reported closure of the institution's graduate program in health education and thus reported no other responses. Excluding this incomplete survey, there were 68 surveys utilized in this analysis, for a 64% useable response rate. The graduate programs were divided into three groups. Group A consisted of schools of public health and MPH programs in Community/Preventive Medicine. Group B consisted of MPH in Community Health Education programs, and Group C were other graduate schools that offered a specialization in community health education at the Master's degree level. The useable response rate among Group A was the lowest with 16 of the 34 programs responding (47%). Responses were highest among Group B with 13 of the 17 programs responding (77%). Among Group C, 39 of the 55 responded, for a 71% response rate. Responses from each of these three types of graduate programs to each of the survey questions will be presented below.

Description of Programs

Survey responses for Group A included 13 schools of public health and 3 other types of MPH degree programs. Group B included 12 MPH in Community Health Education degree programs, along with one that reported to be located within a Health, Physical Education, and Recreation (HPER) organizational structure. Group C data included 12 HPER programs, 12 stand-alone health education programs, and 15 within the "other" category. Of those in the "other" category from Group C, 5 reported being located within Health Science departments, 3 within Colleges of Education, 2 within allied health programs, 2 programs that self-reported being MPH in Community Health Education programs, which left 1 each in a school of medicine, a department of public health, and in a health promotion program. The author realizes that several master-level programs in health education are currently revising their curricula with the intent of moving toward the MPH in Community Health Education, which may explain the discrepancy between the program's listing in the AAHE Directory and how the respondents described their program in the survey.

Table 1: Faculty and Departmental Profile By Type of Degree Program

	Group A Programs	Group B Programs	Group C Programs
# Responding	16	13	39
# CEPH Accredited	14 of 16 (88%)	12 of 13 (92%)	4 of 39 (10%)
Average # of Full-time faculty	8.1 (121/15 responses)	7.3 (94/13 responses)	5.6 (217/39 responses)
Average # Full-time faculty with health education graduate degree	5.1 (77.5/15 responses)	4.8 (63/13 responses)	4.2 (162.5/39 responses)
Average # of Full-time faculty w/CHES	1.2 (17.5/15 responses)	2.8 (37/13 responses)	2.2 (87/39 responses)
Faculty Workloads: Teaching	35%	68%	59%
Research	43%	18%	27%
Service	22%	14%	14%

As can be seen from Table 1, a total of 88% of Group A programs (14 of 16) reported being accredited by CEPH. Similarly, 92% of Group B programs (12 of 13) reported being CEPH accredited. In contrast, only 10% of Group C programs (4 of 39) reported being accredited. Of the five Group C respondents who thought their programs were accredited, two indicated that they were NCATE accredited (most likely responding in terms of their NCATE accredited undergraduate programs), one indicated that the program was accredited by CEPH, and one gave no response to this question. Since few of the Group C programs reported being accredited, the responses of this group were analyzed for one additional question: "Do you believe the majority of your health education graduate faculty would favor and support having your graduate program undertake completing a self-study and undergoing external review (site visit) in an effort to obtain accreditation for the master-level program?".

A majority (54%) of Group C program chairs/graduate program coordinators said "Yes" to this additional item.

Another survey question asked the individuals responding to the survey to identify whether they were a chair/department head, graduate program coordinator, or "other" (they were then asked to list their position). Responses showed that 60% of those completing the survey were chair/department heads, 30% were graduate program coordinators, and 10% were "other" (community health education program coordinators or faculty).

One question asked for the number of full-time equivalent (FTE) faculty within the department teaching in the graduate health education program (Table 1). Another question asked, "Of these, how many have a graduate-level, terminal degree in community/public health education?" The next question asked how many in this second group had the CHES credential. Results are listed in terms of total faculty numbers in Table 1. Analyzing the data from Table 1 within each group indicates that the average faculty FTE for Group A was 8.1, as compared to 7.3 for Group B, and to 5.6 for Group C. However, the average number of faculty who were CHES was 1.2 for Group A, 2.8 for Group B, and 2.2 for Group C.

The breakdown for tenure-track faculty workloads based upon the average of the total responses for all three program groups is as follows: 55% for teaching, 29% for research, and 16% for service. The figures in Table 1 indicate considerable differences in workload allocation between the three different program groups. For Group A respondents only, the average breakdown for recommended workloads was: 35% for teaching, 43% for research, and 22% for service. These recommended percentages were quite different, however, for Group B, with 68% being recommended for teaching, 18% for research, and 14% for service. Group C data for average recommended allocation was 59% for teaching, 27% for research, and 14% for service.

Support for NCHEC's Areas of Responsibility

Three survey questions addressed the graduate degree program's involvement with, and level of support for, the NCHEC responsibilities and competencies for entry level health educators. The first question asked "Is your department's graduate (master's level) health education curriculum intentionally designed to prepare students to take the CHES examination for entry-level skills?". Response choices were: (a) Yes, (b) Not intentionally, but it does cover all of the CHES competencies, and (c) No, it is not designed for this purpose, nor does it cover all of the CHES competencies. Results are listed in Table 2.

Combining data from the "Yes" and "Yes, but not intentionally" columns from Table 2 show that 81% of the graduate programs responding to this survey reported that their curricula prepared their students to take the CHES examination, though a lesser percentage (38%) reported that their graduate health education program was intentionally designed for this purpose.

The second survey question asked respondents to provide the percentage of the program's recent graduates who had taken the CHES exam. A total of 55 of the 68 surveys had responses to this question, with six of the 55 reporting zero percent having taken the CHES exam. The average for all three groups combined was 32%. For the 12 respondents from Group A, their average was 12%; for the 11 respondents from Group B, the average was 34%; and for the 32 respondents from Group C, the average was 39%.

Table 2: Do Graduate Programs Intentionally Prepare Students for CHES Exam?

Group	Yes	Yes, but not intentionally	No, not covered	Total responding
Group A	2	9	5	16
Group B	6	6	1	13
Group C	18	14	7	39
Totals	26	29	13	68
Percent	38%	43%	19%	100%

The third survey question asked "How beneficial for the career advancement of your students do you feel taking and passing the CHES examination to be?" A five-item scale was used with choices ranging from 1 (Of no benefit) to 5 (Of great benefit). Results showed that 4% responded with choice 1; 22% selected response 2; 32% circled response choice 3; 24% indicated response 4; and 18% chose response 5. Combining response choices 4 and 5 showed that 42% of the chairs/graduate program coordinators responding to this survey thought that taking the CHES exam was beneficial for their graduates. Combining response choices 4 and 5 by program group shows that 31% of both Group A and Group B and that 50% of Group C program chairs thought that taking the CHES exam was beneficial for their graduates.

Support for Joint Graduate Standards

Several survey items related to issues surrounding the use of the Joint Graduate Standards. One survey question asked "What is your personal level of support for the expanded, graduate-level health education competencies proposed by SOPHE/AAHE?". Using a similar 5-item scale, of the 67 individuals who responded to this question, 4% indicated response 1 (Little or no support), 9% chose response 2; 20% indicated response 3; 28% selected the fourth response; and 39% indicated response choice 5 (Very high level of support). Again, combining the percentages from response choices 4 and 5, 67% of the chairs/graduate program coordinators indicated a high or very high level of support for the Joint Graduate Standards. Examining the percentage breakdown within each group for the combined responses 4 and 5, Group C showed the highest level of support (31 of 38 programs for 82%), followed by 62% of Group B (8 of 13), and 40% of Group A (6 of 15).

A related item asked "Does your graduate faculty intend to modify the health education curriculum in any way in order to insure coverage of the new graduate-level competencies?".

Responses to this question were 59% "Yes" with 41% indicating "No". Here too, when looking at the percentage breakdown within each group, Group C had the highest percentage intending to modify their health education curriculum (70%), followed closely by Group B (58%). Group A responses indicated less percentage intending to modify their curriculum (29%).

A third survey question related to the graduate competencies asked "Do you believe the Council for Education in Public Health (CEPH) or a similar graduate-level accrediting body should require academic programs to provide evidence on how they are covering the new graduate-level health education competencies within their curriculum?". Though the survey responses were only "Yes" and "No", five respondents created a third choice–"Don't Know". This suggests that the overall percentages may well have been different if there had been a third response category in the survey for "Don't Know". The combined response data available suggest that more than half of the responding programs support the idea of having graduate programs provide evidence of how their curriculum addresses the new Joint Graduate Standards, with 57% responding "Yes", as compared to 35% responding "No", and 8% responding "Don't Know". As can be seen from Table 3, Groups A and C were more supportive of this idea than Group B.

Table 3: Support for Graduate Standards and Related Issues

	Response Total	Group A	Group B	Group C
% Support for Graduate Standards: High/highest level of support (responses 4+5)	67%	40%	62%	82%
Medium support (response choice 3)	20%	33%	31%	9%
Little or no support (responses 1+ 2)	13%	27%	7%	9%
% Intending to modify curriculum	59%	29%	58%	70%
% Believing graduate programs should address graduate standards	57%	62%	31%	64%
% Wanting Advanced Level Examination	52%	50%	50%	56%
% Supporting Formation of Council	80%	69%	85%	92%

A fourth survey question asked "do you believe NCHEC should offer a CHES examination for advanced level practitioners (including those with a master degree in health education)?". Of the combined 63 respondents to this question, 52% said "Yes", while 48% said "No". As can be seen from Table 3, the percentages within each group responding "Yes" to this question were also about the same, varying between 50 to 56% affirmative.

Another question in this section asked "Do you support the formation of a council or workgroup to increase collaboration between, and to represent the needs of, graduate-level preparatory programs in health education?". Results showed 80% of respondents reported support for the formation of such a council, compared to 16% indicating "No" and 2% adding a new response choice of "Don't Know" and 2 with no response (3%). The last item in Table 3 shows greater support for the formation of a council among Groups B and C when compared to Group A responses.

Discussion

The results of this study confirmed the support for both the NCHEC competencies and for the Joint Graduate Standards among graduate (master-level) programs in community health education. A limitation of this study was its reliance on self-report data. While asking any single individual to provide responses to the survey items is risky, the author of this study thought that seeking such responses from the degree program chair/department head or graduate program coordinator would be the best choice if one assumes such individuals are in the best position to comment upon such issues.

Concerning the three questions designed to measure support for the NCHEC responsibilities and competencies, results showed mixed support. The majority (81%) of the chairs/graduate program coordinators responding to this survey said their program's curriculum prepared students to take the CHES examination, yet only half this number (42%) thought that taking the CHES exam was beneficial for the career development of their graduates. Perhaps

such beliefs among the program leadership had some influence on the number of recent program graduates who took the CHES exam (with an estimated average for all three groups of only 32%).

Though overall support among the survey respondents for the NCHEC competencies may not have been very high, in contrast, two-thirds of these same individuals indicated a high or very high level of support for the SOPHE/AAHE Joint Graduate Standards. Support was higher among Groups B and C than Group A. This same pattern of support between the three groups was also noted among those respondents who reported that their respective faculties intended to modify their health education curriculum in order to insure coverage of these Joint Graduate Standards. This suggests that while the value of the CHES exam among many graduate programs may not be rated too highly at the time of this survey, there was a stronger appreciation for the value of the Joint Graduate Standards. Perhaps the respondents felt the Joint Graduate Standards to be more relevant to graduate education. There was support (57%) for CEPH to require academic programs undergoing accreditation review to provide evidence on how they are covering the Joint Graduate Standards, as well as support for NCHEC to offer a CHES exam for advanced level practitioners (52%). According to Merrill, Chen, Gielen, et al (1998), NCHEC is exploring the feasibility of certifying health educators at the advanced level.

There was also considerable overall support (80%) for the formation of a council or workgroup to increase collaboration between, and represent the needs of, graduate-level health education programs. Indeed, several chairs from MPH in Community Health Education programs recently created such a council entitled "Council of Accredited MPH Programs in Community Health Education", which recently approved its own by-laws and is under the leadership of Dr. Bill Livingood from East Stroudsburg State's MPH program.

The data about the type and size of the programs responding was also revealing. The results suggest that a majority of those chairs of graduate health education programs not accredited at the time of the survey believed that their faculty would support undertaking the self-study and external site visit review required to obtain accreditation. Though in principle these programs would be eligible to undergo CEPH accreditation review, it seems that they may be unaware of this fact, believe their faculty and other resources are inadequate to support pursuing such an demanding undertaking, or are possibly unwilling to undertake such an effort for other reasons. The need to expand quality assurance mechanisms, including accreditation efforts, to other graduate programs was recently discussed at the SOPHE/AAHE co-sponsored invitational meeting held January 15 and 16, 2000 in Dulles, Virginia. The overall purpose of this meeting was to examine future directions for quality assurance in professional preparation in health education. The ideas generated during this meeting were a follow-up to the report "Health Education in the 21st Century" (Brown, Cissell, DuShaw, Goodhart, McDermott, Middleton, Tappe, & Welsh, 1996). The issues raised and recommendations made at the meeting are to be discussed at the both the SOPHE and AAHE executive committees during 2000, with a likely result being endorsement of plans to solicit profession-wide input. To meet the accreditation needs of the "non-MPH" master-level graduate health education programs, CEPH might consider expanding its marketing efforts to encourage participation of the other types of master-level graduate programs, and/or the SOPHE/AAHE executive committes may wish to have the SABPAC expand its mission to include programmatic review of such graduate programs. The health education profession is also undertaking an update and validation of the entry-level as well as advanced level responsibilities and competencies through the work of the Competencies Update Project or CUP. Information on the purposes and progress of the CUP can be found at the following internet address: http://www.nchec.org/cupproj.htm.

The differences in average faculty FTE among the three groups were noteworthy. While those programs from Group A averaged 8.1 FTE faculty (and 7.3 FTE from Group B), the average size of the graduate programs from Group C was 5.6 FTE. Also, differences in recommended faculty workloads among the three groups of degree programs were interesting, with programs from Group A requiring less effort in the area of teaching and more in the research area than the other two groups. Such differences in the recommended workload allocations for teaching versus research noted between the groups should be of

particular interest to those conducting site visits and leading programmatic reviews, as well as those sitting on accrediting boards who must make determinations regarding accreditation status for such programs.

In conclusion, there is support among the respondents to this survey for the NCHEC responsibilities and competencies, for the CHES examination process, and for the Joint Graduate Standards. In future research of this type, more sophisticated qualitative assessments–such as using focus groups of department chairs to generate survey items–as well as efforts to formally establish survey reliability and validity should be undertaken. The results of this survey offer a snapshot in time (November, 1997 to January, 1998) of program characteristics and the level of support for both the NCHEC Competencies and the Joint Graduate Standards. The author hopes to repeat this survey sometime within the next decade in order to determine any changes in the pattern of responses.

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