National Conference for Institutions Preparing Health Educators

February 5-7, 1981
Birmingham, Alabama

Proceedings

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Foreword

The National Conference for Institutions Preparing Health Educators represents an important milestone for academic leaders in health education, and I am pleased that the Public Health Service has played a role in sponsoring it. Two hundred fifty conferees representing nearly 100 training programs affirmed their commitment to preparing practitioners to make the best possible contribution to programs directed toward the goals and objectives of Healthy People, the Surgeon General's report on Health Promotion and Disease Prevention, and Promoting Health/Preventing Disease: Objectives for the Nation.

Conference deliberations centered on credentialing and curriculum issues related to the national Role Delineation Project for health education currently being conducted under contract from the Public Health Service's Bureau of Health Professions to identify generic functions and core competencies for health educators working in schools, clinical settings, worksites, and the community. Out of this thoughtful discussion and debate came recommendations for future project directions, the National Task Force for the Preparation and Practice of Health Educators, and their own training programs in colleges and universities. In addition to these recommendations, the conference's proceedings contain papers addressed to such key topics as the competencies needed in the major practice settings now and in the future and the mechanisms through which schools can meet their responsibility to the public in assuring this preparation.

It is clear that attainment of our national goals and objectives is dependent upon effective efforts to motivate people to enhance their own health-related practices. While the success of these efforts requires the participation of a variety of professionals, indeed, of every citizen, the responsibility for leadership lies with the health educator.

These proceedings should be both a stimulus and a guide to further growth in the potential for that leadership, as it emerges through individual academic programs as well as at the national level.

J. Michael McGinnis, M.D.
Deputy Assistant Secretary for Health
and Assistant Surgeon General

Preface

If it had been suggested ten years ago that a conference be held among health educators from all practice settings for any purpose, let alone to discuss the role of a generic health educator, it would not have happened. There were exceptions, of course, but health educators in school, community, and medical care settings simply did not communicate with one another. Their preparation, functions, and even language usage were significantly different.

What, then, were the factors that made meeting in Birmingham not only attractive but mandatory? I will attempt here to identify some of the more significant of these factors. The rising costs of our health care system together with an ever-increasing number of health problems have increased the prominence of health promotion and disease prevention in national thinking. That is, if spending more money to treat illness is not a solution to achieving good health, perhaps the answer lies in assigning greater resources to preventing disease and promoting wellness.

The structure of the National Coalition of Health Education Organizations illustrates the fact that the health education profession has grown up in several different ways, under several different auspices: Within the coalition are eight different national organizations with varying areas of concentration, all committed to health education. As a consequence, a health educator can belong to one of these organizations without communicating with members of the other organizations. With communication thus limited, understanding is next to impossible. At the same time that health educators continued to work separately, without a unified approach to health education, professionals in other disciplines began to advertise their involvement in the field, without the benefit of preparation in health education. Since 1960 an increase of over 200 percent in the number of professional preparation programs has been accompanied by little attempt at standardization of preparation, quality control, or placement of graduates. The availability of financial

resources through emphasis on promotion and prevention, the proliferation of preparation programs without unifying factors, and the intrusion of unprepared practitioners into the field combined to provide incentive for health educators to "get their act together."

In the summer of 1978, a small group representing all practice settings met and agreed to discuss these issues openly and to decide upon a course of action. As a result, the Division of Associated Health Professions, U.S. Bureau of Health Manpower, sponsored a meeting of a representative sampling of health educators February 15-17, 1978, in Bethesda, Maryland. Participants in the Bethesda conference discovered considerably more likenesses than differences in the preparation and practice of health educators. Upon the recommendation of this conference, the National Task Force on the Professional Preparation and Practice of Health Educators was established and charged with developing a plan of action leading to a credentialing program for the entire field of health education. The National Conference for Institutions Preparing Health Educators, held February 5-7, 1981, in Birmingham, Alabama, was a significant step in this plan.

Credentialing is an umbrella term for the mechanisms used by a field of practice to designate to both provider and consumer type and quality of practitioner. Among these mechanisms are accreditation, licensure, certification, and/or registration. Any or all of these mechanisms may be part of the credentialing process, but the deecision of whether to credential itself and, if so, which mechanisms to use is up to the field of practice. Although the health education profession has strongly supported the suggestion of a credentialing system, it has not agreed upon which mechanisms to include in that system.

In October 1978, the National Task Force was successful in obtaining funds from the Bureau of Health Manpower (now the Bureau of Health Professions) to support the first phase of its task--initial role specification. In the same month the Role Delineation Advisory Committee (RDAC)--comprising representatives of the eight national health

education organizations; a chairperson, and a consumer representative--was established. The committee employed a director of the Role Delineation Project in January 1979, who began to work with the Role Delineation Working Committee (RDWC) to develop the initial role specification document. Completed in January 1980, this document was disseminated to all professional preparation programs in the United States through presentations at local, state, regional, and national meetings and was published in full in the July 1980 issue of Focal Points, jointly released by the Bureau of Health Education and the Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine.

In May 1980, the National Center for Health Education was awarded a contract to complete the second phase of the Role Delineation Project--"Role Verification and Refinement." The Role Verification Working Committee (RVWC) is presently conducting a survey to determine whether the initial role specification statement accurately reflects the current situation in various practice settings. This phase of the project is to be completed by August 1981.

Completion of the remaining phases of the project depends upon funding. These phases include Phase III: Preparation of Educational Resource Document; Phase IV: Development of Self-Assessment Instruments for Practitioners; and Phase V; Development of Continuing Competency Materials. With the role delineation activities in process, the National Task Force gave consideration to a meeting of representatives of the professional preparation institutions in an effort to involve these institutions more closely in the process of determining the role of the health educator. The Birmingham conference was planned to coincide with the meeting of the Verification Committee to allow the institutions maximum contribution to defining the role of the health educator. The National Conference Planning Committee, formed in July 1980, conducted a needs assessment survey of all the health education professional preparation institutions in the United States. These institutions were asked to indicate their interest in and ability to provide representatives to such a conference, their familiarity with

role delineation issues, and other issues in health education of importance to them. Within two weeks, over 75 percent of the institutions surveyed responded favorably to the suggestion of a national conference on role delineation.

The conference was scheduled for February 1981 under the sponsorship of the National Task Force; the Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine of the U.S. Department of Health and Human Services; the Bureau of Health Education (now part of the Center for Health Promotion and Education), USDHHS; the Office of Comprehensive School Health, U.S. Department of Education; the Bureau of Health Professions, USDHHS; the National Center for Health Education; the Coalition of National Health Education Organizations; and Eta Sigma Gamma. The host for the national conference was the School of Education, University of Alabama in Birmingham.

The Planning Committee set the following conference goals:

- To identify institutional responsibilities and options in credentialing health educators
- To examine the credentialing process as it applies to the preparation of health educators and to establish criteria for the entry-level health educator
- To identify the responsibilities of the health educator in relation to Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (1979) and Promoting Health/Presenting Disease: Objectives for the Nation (1980)
- To recommend to the National Task Force mechanisms for credentialing health educators.

A significant number of individuals representing most of the institutions surveyed attended the conference in addition to representatives of local, State, and Federal government agencies as well as international organizations. It was clear that timing of this conference was right: Professional preparation institutions were ready to talk about role delineation and its implications for credentialing. The conference

was designed to provide ample opportunity for participants to contribute to the initial role specification statement, to comment on the verification process strategy, and to comment on both whether the credentialing initiative should continue and what part institutions should take in the process.

In planning the conference, the committee tried to strike a balance between substantive presentations and group discussion to allow maximum contribution by the participants to the role delineation and credentialing processes.

The six major recommendations that evolved from the conference are as follows:

- That the Role Delineation Project continue
- That the role specification statement have a mission statement and a preamble preceding discussion of the role itself
- That the verified and refined role specification statement represent accurately the role of the entry-level health educator
- That the preferred health education credentialing mechanism be identified as voluntary certification
- That communication and marketing be increased within and outside the health education profession
- That the feasibility and desirability of a single national organization to represent health educators be studied.

These recommendations constitute an agenda for professional discussion for the next several years.

I am confident that the Birmingham conference will prove to be a significant milestone in the progress of the health education profession and of its members. I urge you to read these proceedings critically, to continue to contribute to the role delineation process, and to discuss these issues actively with your faculty colleagues, students, and practitioners in your area.

I wish to acknowledge the invaluable contributions to the success of this conference made by the Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine; the Center for Health Promotion and Education, Centers for Disease Control; Ball State University; the University of Alabama in Birmingham; the members of the Planning Committee, particularly Dr. Cleary, Dr. Henderson, Mr. Ogden, and Dr. Mullen; and Mr. Bernard Glassman and Ms. Diane McDonough of JRB Associates.

These proceedings are dedicated to those who made the Birmingham conference possible, to conference participants, and to all health education professionals.

Warren E. Schaller

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National Conference Planning Committee
National Task Force on the
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Practice of Health Educators

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3	Peter A. Cortese U.S. Department of Education	Elizabeth A. Lee American Hospital Association
4	Herb Jones Ball State University	Sheila Gorman Columbia University
5	Elena M. Sliepcevich Southern Illinois University	Elaine M. Vitello Southern Illinois University
6	Alan C. Henderson National Center for Health Education	Sharon Lee Zajac National Conference Planning Committee
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8	Leonard E. Tritsch Oregon Department of Education	Patricia D. Mullen U.S. Department of Health and Human Services
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10	Anna W. Skiff USPHS Hospital Staten Island, New York	Stephen D. Assenmacher Hartland, Michigan, Consolidated Schools
11	Helen P. Cleary University of Massachusetts	Elizabeth Bernheimer University of Nevada
12	Robert H. Conn D.C. Department of Human Services	Laura Anderson Berkeley, California, City Health Department
13	Betty Mathews University of Washington	Marion B. Pollock California State University
14	Helen S. Ross San Jose State University	Charles R. Carroll Ball State University

Group Number	Leader	Recorder
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19	Chet E. Bradley Wisconsin Department of Public Instruction	Cheryl Alexander Indianapolis, Indiana, Division of Public Health
20	Jane Zapka University of Massachusetts	Maureen E. Sullivan USDHHS Bureau of Health Professions

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Agenda

National Conference for Institutions Preparing Health Educators

Hilton Hotel — Birmingham, Alabama
February 5-7, 1981

Role Delineation: Implications for Credentialing

AGENDA

Thursday, February 5

6:00 p.m.
Foyer

REGISTRATION

7:30-9:00
Heritage I

FIRST GENERAL SESSION

PRESIDING: Warren E. Schaller, H.S.D., Chairman and Professor, Department of Physiology and Health Science, Ball State University

WELCOME: Thomas K. Hearn, Jr., Ph.D., Vice President for University College, University of Alabama in Birmingham

C. W. Scott, Jr., M.D., Deputy Dean, School of Medicine, University of Alabama in Birmingham

Milly Cowles, Ph.D., Dean, School of Education, University of Alabama in Birmingham

CONFERENCE OVERVIEW: Warren Schaller

Professional Preparation: An Historical Perspective: William H. Creswell, Ed.D., Professor of Health Education, University of Illinois

The Objectives for the Nation in Disease Prevention and Health Promotion: A Challenge to Health Education Training: Lawrence W. Green, Dr.P.H., Director, Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine, U.S. Department of Health and Human Services

9:00
Alabama Room

SOCIAL
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Friday, February 6

7:30 a.m. Foyer	Continental Breakfast
8:30 Heritage I	SECOND GENERAL SESSION
	CONFERENCE ARRANGEMENTS: Mabel C. Robinson, Ed.D., Assistant Dean, School of Education, University of Alabama in Birmingham
8:45	Conference Design and Anticipated Outcomes
9:00	Credentialing for the 1980s: Raymond D. Salman, Ed.D., Director of Professional Licensing, New York State Education Department
9:45	Perspectives on Role Delineation: Alan C. Henderson, Dr.P.H., Director, Role Delineation Project, National Center for Health Education
10:45 Foyer	Break
10:30 Heritage I	Credentialing: Implications for Health Educators: Panel -- Raymond W. Carlaw, Dr.P.H., Director, Program in Health Education, University of Minnesota; Laura C. Keranen, Lecturer, School of Public Health, University of California, Berkeley; Marian V. Hamburg, Ed.D., Professor and Chairperson, Department of Health Education, New York University
11:15	DISCUSSION GROUP INSTRUCTIONS
11:30	FIRST DISCUSSION GROUP SESSION Role Delineation and Credentialing
12:30 p.m. Foyer	Box Lunch
2:00	SECOND DISCUSSION GROUP SESSION Continuation of morning session
4:00 Heritage I	DISCUSSION GROUP SUMMARY Comments and Directions
5:00	ADJOURNMENT
5:30 Alabama Room	Social Hour Sponsored by Eta Sigma Gamma

Saturday, February 7

7:30 a.m. Foyer	Continental Breakfast
8:30 Heritage I	THIRD GENERAL SESSION Credentialing: Implications for Institutions and Programs: Lee Holder, Ph.D., Dean, College of Community and Allied Health Professions, The University of Tennessee Center for the Health Sciences
9:30	THIRD DISCUSSION GROUP SESSION Personal and Institutional Implications of Credentialing
11:30 Heritage I	Lunch Options and Opportunities: Recommendations for Future Action: Scott K. Simonds, Dr.P.H., Professor of Health Education, University of Michigan
1:00 p.m.	FOURTH DISCUSSION GROUP SESSION Development of Recommendations for National Task Force
3:00 Heritage I	DISCUSSION GROUP REPORTS Response by the National Task Force: Helen P. Cleary, D.Sc., Associate Professor, University of Massachusetts Medical School
4:30	ADJOURNMENT

Discussion Group Summaries

Discussion Group Summaries

Introduction

Participants in the Birmingham conference expressed both enthusiam about their progress and support for continuing the Role Delineation Project. The section of these proceedings entitled "Recommendations of the Conference" demonstrates the consensus of the participants on several important issues. In contrast, this section presents summaries of group discussions that pinpoint those issues requiring further debate.

For example, the issue of balance between process and content appears to be basic to different conceptualizations of the role of the health educator among the professors of health education. This is probably the major issue that must be resolved in the curriculum development phase of the Role Delineation Project.

It is important to identify areas of both agreement and disagreement so that members of the profession can better understand the positions of their colleagues. These topics are appropriate bases for discussion at local, regional, and national meetings of professional organizations and for articles in professional journals. Moreover, airing differences is the best approach to resolving them, wherever resolution is possible. And despite the variety of views expressed in Birmingham, it is clear from both the findings of the Bethesda conference and the recommendations of this conference that commonalities are greater than differences among branches of the health education profession.

Each of the 20 discussion groups met four times. Specific questions were posed for consideration during each session. However, since other, related issues were raised during the discussion of these

questions, we have reported the groups' comments according to the general topic. Those areas of consideration are:

I. The role of the generic, entry-level health educator (as published in July 1980 Focal Points)

II. Certification of the health educator

III. Program accreditation

IV. Institutional implications of role delineation and credentialing

V. Personal implications of role delineation and credentialing

VI. Health educators and disease prevention/health promotion objectives for the Nation

VII. Miscellaneous.

The charge for discussion in Session 4 was to formulate recommendations. Since the outcome of that session is presented in the Conference Recommendations section of these proceedings, we have not included a report of Session 4 in this section.

The differences in tone and content of participants' comments are essential to understanding the current status of the health education profession as seen by its members. In an attempt to preserve these rich data, we have selected representative comments for reporting and have kept editing at a minimum.

Helen P. Cleary, D.Sc.
Associate Professor
University of Massachusetts
Medical School

Phyllis G. Ensor, Ph.D.
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Questions Discussed

Sessions 1 and 2:

(a) Do the responsibilities and functions described in the role delineation documents accurately and adequately describe the role of a generic (i.e., all settings) entry-level health educator?

(b) Do the skills and knowledge described in the role delineation document accurately and adequately describe the role?

(c) How can role delineation for health educators be linked more closely with national health goals, for example, as identified in Healthy People?

Session 3:

(a) What are the current responsibilities of your training program for the credentialing of your graduates?

(b) What options or opportunities do you see for your institution and other institutions in dealing with credentialing of health educators?

(c) Which factors will facilitate and which factors will hinder individual institutions or groups of institutions in dealing with the credentialing of health educators?

(d) What problems do you see in connection with accreditation of academic health education programs? What solutions do you see for these problems?

(e) What are the personal responsibilities to the individual health educator or teacher of health educators in relation to credentialing?

(f) What is the responsibility of training institutions to national goals?

Session 4:

(a) Do we want to recommend efforts be continued to develop a credentialing system for health educators? If not, why not?

(b) What specific directions should the credentialing process take in the immediate future?

(c) What providers should be considered in the planning of next steps?

(d) How should the Task Force relate to, communicate with, or involve training institutions?

(e) Are there sources of funding that should be considered for next steps?

I. THE ROLE OF THE GENERIC, ENTRY-LEVEL HEALTH EDUCATOR (AS PUBLISHED IN JULY 1980 FOCAL POINTS)

There were more comments about the draft role document than any other topic discussed at the conference. Detailed suggestions such as changes in wording are not included here. These have been submitted to the Role Verification Working Committee.

A. General Comments

Appropriateness of "Entry Level" Across Settings

1. Almost all the responsibilities and functions are identical with those other professions would claim (e.g., communicating, administrative functions, etc.). The processes and content are largely shared with all educators, social workers, etc. What really distinguishes health educators from others?

2. The role as defined expects too much of the school health educator.

3. Some responsibilities are not pertinent to patient and school health educators, and all responsibilities are not equally important.

4. The examples refer primarily to community settings. School health educators might be better able to identify with the document if more examples pertained to education settings. Community or public health jargon increases as the document progresses.

Value of Role Delineation

1. The role delineation document could be helpful to the field, e.g.: in making the case for adequate faculty and training resources within universities and colleges; as the basis of job descriptions; in educating employers; and as a "Flexner Report" to improve the quality of health education training.

2. The role delineation document should be the basis for developing standards of practice and for a certifying examination.

Need for Advocacy

1. There is a pressing need to convey the role and functions to both employers and administrators and other decision-makers in training institutions.

2. How will the role delineation document influence employers and their hiring practices? Can it be used to encourage the hiring of trained and eventually certified health educators?

B. Additions to the Role

Frame of Reference

1. The most serious deficiencies identified in the document were: lack of a conceptual framework, specification of assumptions, and a statement of the philosophical and scientific base of practice. As it stands, the document risks being overly technical and present-oriented; it is an admixture of housekeeping and high-level responsibilities.

2. The areas of responsibility, functions, skills, and knowledge, although perhaps generally useful in beginning to delineate the role of the health educator, may be overly technical and mechanistic.

3. A glossary of terms should be included with the document. It should define terms such as planning, budget, and implementation, using examples from health education practice.

4. The role should be rewritten to focus on serving people rather than on program.

5. The role needs greater emphasis on skill development and greater specification of skills.

6. Emphasis should be on the facilitator function rather than on service delivery function.

7. The role needs to convey that health educators do not work in a vacuum but relate to and interact with a variety of social systems.

8. The role as defined seems to focus on the health educator as a transmitter of information and omits the social dynamics of the role.

9. The role does not address the issue of public accountability. It overemphasizes process skills, offers little on interpersonal skills, lacks a philosophical component, and does not address the issue of health educators as role models.

10. Professional ethics should be addressed in the role.

11. The task analysis strategy on which the role delineation is based is questioned.

Content

1. School educators were concerned that no content areas were mentioned in the document. Nowhere is there reference to health, disease, physiology, smoking, nutrition, etc. "Process" dominates. A meshing of content and process needs to occur.

2. Health education deals with health promotion and disease prevention. Neither is visible anywhere in the document. Yet this is what separates health educators from other professionals who may carry out similar functions.

3. There is no reference to the need for knowledge about the medical care/public health system.

4. There is no reference in the role to the impact of systems on the functioning of the health educator.

Supervision

1. There should be reference in the role to the need for supervision of an entry-level health educator.

2. Skills and knowledge for the entry-level health educator should include those that could be performed autonomously, i.e., without supervision.

C. Concepts Related to the Role

Entry Level

1. There is a need to provide further clarification of the term, "entry level." The definition in the initial role specification is confusing. It must be defined more precisely before one can examine areas of responsibility, functions, skills, and knowledge.

2. The role as delineated is an accurate description of a generic health educator, but it goes beyond entry level.

3. Each of the responsibilities in the role delineation document is reasonable for an entry-level health educator. However, the skills necessary to carry out these responsibilities could not possibly be acquired in a baccalaureate program.

4. There should be an indication of the degree of proficiency expected of an entry-level person in responsibilities, functions, skills, and knowledge.

5. It is difficult, if not impossible, to prepare an entry-level health educator for all settings.

Generic

1. Can there be a generic, entry-level health educator? The positions health educators have are so diverse. Would a generic educator be "a jack of all trades and a master of none"?

2. There is a common thread that "runs through" the practice of health education in all settings.

Specialization/Career Ladder

1. The concept of beginning with a generic role is acceptable. However, a mechanism needs to be established to accommodate a specialized focus in practice.

2. There is a need to categorize responsibilities, skills, and knowledge by levels of practice.

3. Does or should a Master's degree connote specialization? At this time, it is questionable whether one can differentiate between a Bachelor's and a Master's graduate in terms of knowledge and skills.

4. Consideration must be given to a professional development ladder. The requirements for the Bachelor's and Master's degrees need to be differentiated.

II. CERTIFICATION

Comments on certification of the health educator included: (a) thoughts about the process, (b) consideration of the value of certification, (c) concerns about the quality of a certification examination, (d) the cost of retraining faculty, (e) the support needed both within and outside the profession for an effective certifying process.

A. Process

1. Factors that will influence the certifying of health educators include: cost to the individual or institution; conflict with existing regulations and/or requirements of a State agency or institution; the employability of program graduates, that is, certified versus non-certified; setting standards that are valid and appropriate; dealing with lawsuits from students who do not pass the examination; the need to educate prospective employers; pressure from third-party payers; and the strength of a professional organization to facilitate the process.

2. Voluntary certification is the preferred method. After a period of experience, the health educator would be eligible to sit for the examination, which should both have a generic base (core) and provide for a specialty track. This method would eliminate the problems inherent in tying certification to graduation from a Bachelor's-level program.

3. The certifying mechanism that is or might be developed should be voluntary rather than mandated, with control, authority, and responsibility in setting standards resting with the profession. Further, it should provide for a grandfather clause.

4. A baccalaureate degree in Health Education should be required at the pre-service level before the educator is eligible for certification.

5. Since certification of health educators would be a national program, reciprocity among States is not an issue. However, since school health educators must be certified by the States in order to teach, reciprocity in this area would be desirable.

B. Value

1. Will certification assure quality in practice?

2. Will certification make the health educator more employable?

3. Will certification protect the public?

4. Is certification the "way to go" at this point in history? What are the dangers or unintended negative effects of this process?

5. Certification of the health educator is preferable to accreditation of a program. It is less expensive and easier to accomplish.

6. Some type of certification is needed. The contribution of the health educator vis-a-vis other professions must be identified and receive a stamp of approval.

7. How will certification affect liberal education courses at the baccalaureate level? Will professionalization narrow the education when openness to ideas and creativity is needed in health education?

C. Examination

1. Concerns over the certification exam include: Who does the testing? Who develops the test? What kind of test should be used, and how will skills be examined? An examination may be necessary but not sufficient in determining competency.

D. Cost

1. The cost to institutions for meeting standards for certification of graduates needs to be considered. The training

of faculty to qualify at the entry level for some of the skills and knowledge will be a major expense.

E. Support Needed

1. There is a need to educate policy-makers, employers, and consumers about certification in order to gain support.

2. An effective certifying process demands a united profession. Can or will health educators come together to support this effort?

III. PROGRAM ACCREDITATION

The discussion about accreditation was not extensive. Thoughts were expressed about: (a) program accreditation; (b) the link between accreditation and certification; (c) the value of accreditation.

A. Program Accreditation

1. A major problem with accreditation is the financial burden and the difficulty of convincing administrators that programmatic accreditation is worth the expense. For many institutions programmatic accreditation would not be acceptable.

2. If there is programmatic accreditation, it should include a large self-study component and should not be under the auspices of any one of the existing accrediting or professional organizations.

3. At the program level, recognition may be more appropriate than accreditation. Recognition by a professional association, on a voluntary basis, would be less expensive than accreditation.

4. The current programmatic accreditation process is unfair; programs in schools of public health receive accreditation if the school is accredited. Programs in non-schools of public health must go through a rigorous, time-consuming, expensive process to receive accreditation.

5. North Carolina has a voluntary registration program of graduates of "approved" schools. A school accredited by some formal body fulfills the criteria for "approved."

B. Link Between Accreditation and Certification

1. Students should be able to be certified even if the health education programs in their schools are not accredited.

2. A student should have to graduate from an accredited program before being eligible for certification.

C. Value of Accreditation

1. Program accreditation is a requirement for receipt of Federal funds.

IV. IMPLICATIONS OF ROLE DELINEATION AND CREDENTIALING FOR INSTITUTIONS

The comments on the implications for institutions of role delineation and credentialing fall into four categories: (a) institutional response to the process; (b) the effect of role delineation and credentialing on institutions; (c) institutional responsibility to health educators; (d) responsibility for the institution's health education program.

A. Institutional Response

1. There is a need to develop a specific credentialing mechanism in the field of health education that provides standards for the preparation and practice of health

educators in any practice setting. Despite considerable barriers to credentialing, once a single mechanism is developed and accepted, institutions and individuals would commit themselves to overcoming barriers such as costs in order to enaure that quality and standards in health education are being upheld.

2. Inatitutions may wish to avoid the issue of upgrading training of health educators. Reduced enrollment is a strong possibility for most institutions. Quality control of health education offerings has the potential for further reducing enrollment. The temptation to ignore the latter may be great for some institutions.

B. Effect of Credentialing and Role Delineation on Institutions

1. Credentialing may force training institutions to develop stronger programs or, if they are unable to do so, to close shop. Therefore, credentialing should be entirely voluntary, with no stigma attached to institutions that cannot live up to prescribed standards.

2. The credentialing process will upgrade the quality of programs and may force marginal programs to terminate.

3. Most Bachelor's-level programs are weak in the behavioral sciences. Many faculty in departments of health education are not trained to teach process skills. Linkages with other departments (an interdisciplinary faculty) are one way to deal with this issue.

C. Institutional Responsibility to Health Education Practitioners

1. Participate in (promoting, sponsoring, cosponsoring) continuing education programs for the practitioner, and monitor the quality with rigor.

2. Sponsor regional meetings to encourage more participation and discussion of the role delineation and credentialing processes.

3. Organize statewide committees of all institutions to assess options available to students, e.g., transfer of courses, the consortium approach, etc. These mechanisms can make use of scarce resources and provide content or skill training lacking in a given program.

D. Responsibility for the Institution's Health Education Program

1. Consider the quality of their programs and teachers. Faculty must be qualified.

2. Not overextend their resources to develop a community health education program, and thereby destroy a good school-oriented program.

3. Look at program honestly (difficult) to determine whether they are preparing health educators for settings in which they are really needed.

4. Develop quality assurance mechanisms including advisory boards, use of existing standards and guidelines, careful selection of field supervisors.

5. Begin to use the role delineation document in a positive way, e.g., as a curriculum guide, while the processes of verification and adoption are going on at the national level.

6. Compare current offerings in health education with the requirements of role delineation.

7. Develop a pilot curriculum for skills and knowledge required by role delineation and for the generic health educator.

8. Conduct faculty in-service training; discuss options and opportunities related to credentialing.

9. Share experiences in gearing up for credentialing with other institutions.

10. Advocate the credentialing process with State certifying and standard-setting agencies.

11. Determine the critical faculty mass needed to train an entry-level health educator.

V: PERSONAL IMPLICATIONS OF ROLE DELINEATION AND CREDENTIALING

The comments on the personal implications of role delineation and credentialing fell into two categories: (a) the individual's responsibility to work with others; (b) the individual's responsibility to improve and/or update his/her skills and knowledge.

A. Individual's Responsibility to Work With Others

1. All attending the conference must share with faculty and administration in their universities what occurred at the conference, what has been done, and what has yet to be accomplished in role delineation and credentialing.

2. Work with administrators to remove barriers such as restricting course offerings that may be essential for certification or needed for continuing education.

3. Organize state and/or local groups to discuss, promote, and implement credentialing issues.

B. Individual Initiative

1. Faculty should have a positive attitude regarding credentialing, emphasizing cooperation, compromise, and communication.

2. Faculty have a responsibility to meet the standards, as demanded, in the future and to revise curriculum accordingly.

3. Individual health educators must continue to grow professionally. Continuing education is one mechanism for professional growth.

4. The role delineation document can be used for self- and departmental review. It requires that everyone do some rethinking (we are not critical enough of ourselves).

5. Faculty have a responsibility to keep up to date, i.e., upgrade their skills and knowledge especially as these relate to process.

VI. DISEASE PREVENTION/HEALTH PROMOTION OBJECTIVES FOR THE NATION

Discussion on Objectives for the Nation included the following categories: (a) the value of the document; (b) the relationship of the document to role delineation; (c) the effect of the document on training programs; (d) the contribution of the health educator to meeting the objectives.

A. Value of the Document

1. Promoting Health, Preventing Disease: Objectives for the Nation should be used to determine pertinent content of the generic, entry-level health educator needs. The information in this document would also be useful in determining the types of continuing education needed by

practicing health educators. This document and Healthy People provide the content the role delineation document lacks.

2. Healthy People can provide leverage for creation of priorities for course requirements for health educators, undergraduates, and graduates and for continuing education courses. Some, however, preferred local autonomy in deciding on priorities for courses.

3. Objectives for the Nation can be used to build linkages between health administration, health promotion, and health education. The needs identified in this document justify the work of the health educator.

B. Relationship to Role Delineation

1. The areas of responsibility in the role delineation document should be preceded by a statement that indicates the application of these responsibilities to the national health goals. Also, the examples in the document should relate to the topics included in the national health goals.

2. Role delineation efforts integrate logically with the thrust to meet national health goals by 1990.

C. Effect on Training Programs

1. The Objectives for the Nation are categorical. Is it wise to train health educators on categorical lines, losing sight of our overall goals and mission? Health is a generic, not a categorical, concept. There is or should be more to health education than striving for reduction of morbidity and mortality from specific diseases.

2. Institutions training health educators need to focus on the 15 areas in Objectives for the Nation, perhaps eliminating some topics in our current training programs.

D. The Health Educator's Contribution

1. Health educators have a definite contribution to make to the accomplishment of the Objectives for the Nation. Therefore, the health educator should be equipped to contribute to these goals and to health promotion (beyond the medical model).

2. It is important to define realistically the health educator's contribution to the national health goals.

3. The role school health educators can play in meeting the national health goals needs to be articulated.

VII. MISCELLANEOUS

A number of comments made at the conference, although related to the major issues discussed, do not fit under the headings in this summary. These include important ideas covering a wide range of issues. We have reported them separately as follows: (a) marketing the credentialing process; (b) continuing education; (c) ethics; (d) academic freedom; (e) curriculum issues; (f) linkages among branches of the profession; (g) updating the role; (h) professional control; (i) international effect of the role; (j) value of credentialing; (k) teacher certification and role delineation.

A. Marketing the Credentialing Process

1. With a new generation of leaders who are ready to see what we share rather than how we differ within the profession, the time seems ripe for uniting health educators. However, the major task will be to "market" the concept of a

consolidated profession, role delineation, and credentialing to the members of our profession. This "marketing" must receive special attention. It should be made the responsibility of a special committee charged to develop and coordinate strategies for this matter.

B. Continuing Education

1. There is a need for a system of continuing education available to all health educators. Credentialing will force continuing education for practitioners and academicians.

C. Ethics

1. How do we ensure that the practice of health education is ethical?

D. Academic Freedom

1. There is a need to allow for regional and institutional discretion and freedom of individual faculty members to make judgments about preparation needs within the overall missions of their schools and departments.

2. Is there a danger of violation of academic freedom by promoting role delineation, i.e., the possibility of tying institutional funding to a curriculum based on the role as delineated and verified, if this curriculum ill fits the institution's mission and interpretation of preparation needs?

3. We need to be aware of the danger of a vocationally oriented Bachelor's-level program.

E. Curriculum Issues

1. Attention must be given in curriculum development to environmental influences on health status as well as individual responsibility for health status.

2. A requirement that the generic, entry-level health educator have both teacher training experience and a community internship may contribute to greater compatibility between these two branches of the profession.

F. Linkages Among Branches of the Profession

1. There needs to be a liaison between departments of education and departments of public health at the State level to coordinate health education programs.

G. Updating the Role

1. Is there an underlying aura of protectionism in the credentialing process?

2. Is there a need to control the number of community health educators who are trained?

I. International Influence

1. What impact will role delineation have on other countries that prepare their health educators in the U.S.?

J. Value of Credentialing

1. Credentialing would give health education identity and status.

K. Teacher Certification and Role Delineation

1. Consideration needs to be given to reconciling the role as delineated with the requirements for State teacher certification. The latter differ among States, but all require specification of content areas. The requirements for teacher certification of some States may be in conflict with the standards being set by role delineation.

Conference Recommendations

Conference Recommendations

Participants in the Birmingham conference worked in 20 groups of 10 to 12 members each, and all contributed to the recommendations that resulted from the group discussion. Each group selected three recommendations to represent the most urgent issues considered. These issues fall into six categories:

1. Continuation of the Role Delineation Project
2. Additions to the document
3. Definition of mission and conceptual framework
4. Credentialing
5. Communications and marketing
6. Professional organization.

Communications and marketing within and outside the profession elicited the greatest number of recommendations from conference participants. Several of these recommendations called for state and/or regional meetings or workshops to acquaint others with the process, to keep the profession informed about the process, and to contribute to the process.

We urge training institutions and professional organizations to take the lead in forming communications networks in their states or regions. The voluntary organization of groups that assume the responsibility of being informed about credentialing activities will provide strong evidence of interest and commitment by the profession and a forum for feedback from practitioners and academicians about project activities.

The following list is a summary, by subject area, of the predominant recommendations made by the 20 conference groups.

I. CONTINUATION OF THE PROJECT

Nine recommendations favored continuation of the project; six of the nine directed the Task Force to provide leadership for the continuing effort. The recommendations as summarized are:

1. That the National Task Force be directed to continue efforts toward credentialing.

   a. Continue sponsorship by the National Center for Health Education to preclude interruption.

   b. Raise funds from the professional constituency to assure support from that constituency in the continuing efforts.

2. That the conference endorse the concept of role delineation for health educators.

3. That the conference endorse the format and process being followed for role delineation.

II. A MISSION STATEMENT AND A PREAMBLE TO THE ROLE DEFINITION

Three of five recommendations specified concepts to be included in a preamble to the role definition. Two recommendations called for two mission statements, one dealing with the profession's contribution to the goals of the nation and the second, with the needs of the profession. The recommendations as summarized are:

1. That the Task Force supervise the development of a position paper detailing how health educators will contribute to meeting the Objectives for the Nation; that the Task Force seek endorsement for this position paper from policy-makers, consumers, and other professions.

2. That the Task Force draw up a mission statement including the concept of health education as a single profession and a plan for credentialing to apply to health educators in all settings.

   a. Continuing education needs should be specified in the plan.

   b. Legal liability resulting from defining our "scope of practice" should be addressed.

3. That the role delineation document include a statement of philosophy and assumptions underlying the role definition and the objectives and of the conceptual framework of the role definition.

III. ROLE DEFINITION AND VERIFICATION

Three of the five recommendations concerned acceptance of the role, as described, for an entry-level health educator; one addressed the need for a definition of "entry level"; and one suggested a way to involve members of the profession in the verification process. The recommendations as summarized are:

1. That the role as delineated be revised to be more realistic for an entry-level health educator. It is too sophisticated for that level.

   a. The role definition should be more general so as to permit flexibility in implementation.

   b. The role should include a "core" common to health educators practicing in all settings.

2. That "entry level" be defined. This definition is critical to acceptance of the role definition.

3. That the verification process begin with institutions, followed by review by (relevant groups) at the state level and then by regional conferences; the regional conferences would give feedback to the National Task Force.

IV. CREDENTIALING ISSUES

There are four categories of recommendation on credentialing issues: acceptance of the concept of standards for the profession; characteristics of the certifying process; structure of a credentialing organization; and the need for more data on the costs of credentialing and health education manpower needs. The recommendations as summarized are:

1. That professional standards be established.

2. That the role delineation document be used as a basis for the development of "standards of practice."

3. That credentialing take the form of voluntary certification administered after a certain amount of experience and represent a person's achievement of an acceptable standard of practice.

   a. The certifying examination should both have a generic base and provide a specialty track.

   b. Certification of community health educators should be separate from that of school health educators and take place one year postgraduation, after full-time employment.

   c. Certification should provide for a "grandfather" clause.

4. That the National Task Force, representing the eight national professional organizations and the representatives to the Coalition of National Health Education Organizations, design

and implement a formal, explicit process during which the professional organizations will consider and present recommendations for a unified vehicle to implement a national credentialing initiative.

5. That more data be gathered about the cost of accreditation/certification in all settings about health education manpower needs.

V. COMMUNICATIONS AND MARKETING WITHIN AND OUTSIDE THE FIELD

Twenty-four recommendations on communications and marketing were made. Eight of these were addressed to the need to inform others about the project and to involve a number of non-health educators in the process; seven recommended additional conferences for institutional faculty and for practitioners; six called for greater involvement of health educators in decision-making related to the project; and three specified certain kinds of communication within the field. The recommendations as summarized are:

1. That the communications network be expanded to include administrators, (employers), certification personnel in State departments of education, and consumers.

   a. As the project develops, engage appropriate experts, e.g., curriculum and evaluation specialists.

   b. Establish increased visibility as a result of the expanded network.

2. That a dialogue be established among academicians, practitioners, and employers to discuss credentialing issues.

3. That publicity be encouraged in business and industrial journals, women's/parents' magazines, etc., regarding the relationship between health promotion and role delineation/health education.

4. That the Conference of Institutions Preparing Health Educators be reconvened in 1-3 years to reaffirm the commitment of the participants and to keep them informed and involved, and that in the meantime, the work of the Birmingham conference be continued on a regional basis, involving younger faculty and more "grass-roots" people.

5. That funds be solicited from health agencies and industry to convene a conference of practitioners.

6. That state associations and organizations sponsor workshops and seminars to inform and stimulate discussion about role delineation and credentialing.

   a. Training institutions and practicing health educators should meet at least regionally to provide a system of checks and balances for the proceedings of this conference and the credentialing process.

7. That leadership on the Task Force be broadened to include professional preparation institutions. Criteria for selecting institutional representation: region, specialty, size of program, representation of private and public schools.

   a. Special efforts should be made to involve programs focusing on ethnic minorities.

8. That leadership on the Task Force be broadened to include more practitioners and non-health educators, and that input from practitioners be sought at each stage of the project.

9. That strategies be developed for marketing the concept of credentialing among training institutions and the leadership of the several health education organizations.

10. That each participant in the Birmingham conference act as a communications link with colleagues and training programs in his/her area.

11. That a voluntary ad hoc professional group be identified, independent of the Task Force, to collect feedback from institutions regarding pilot activities undertaken based on the role delineation document. This group should function immediately and assemble within a year to review and catalog the information--i.e., test instruments, faculty meetings, curricula changes, etc. The ad hoc group should report to the Task Force/Coalition.

VI. ONE PROFESSIONAL ORGANIZATION

Five of the seven recommendations called for a new national professional organization, and two suggested the unification of the "old" organizations into a single association. The recommendations as summarized are:

1. That strong consideration be given to forming a new national professional organization to correct the fragmentation now existing among eight professional organizations.

2. That efforts be pursued toward unification of the several organizations of health educators into a single association.

VII. OTHER

1. That review and consideration be given to what may be the wider social changes (i.e., post-industrial social realities like demographic shifts, role of the family) in influencing the special role of the health educator. (This recommendation will be referred to the working committee for the third phase of the project, i.e., the curriculum development phase.)

2. That the National Center for Health Education begin an immediate job search and referral service. Job opportunities in all settings--community, school, and medical care--would/could be sent to NCHE, and graduates could pay a small service fee for this generic list of available positions at all levels, i.e., B.S., M.S., and Ph.D. (This recommendation has been referred to the National Center for Health Education.)

Presentations

Professional Preparation: An Historical Perspective

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The following statement might have been issued as a charge to this role delineation conference in 1981:

> Recognition of the need for greater clarification of the role of public health educators--and for more adequate preparation of these professional workers--provided incentives for this study.

But, in fact, did this appear in 1981? No, Robert Bowman wrote this in 1958, as a preface to a study that he had conducted during the period of 1953-1956--over 25 years ago. It might seem, therefore, that the field of health education is either endlessly repeating itself, or else standing still. Instead, a study of the history of the last 40 years reveals again the validity of Shakespeare's familiar line, "What's past is prologue." A professional colleague (Sheps, 1975), writing about contemporary trends in public health, states the concept in more forward-looking terms: "In today walks tomorrow."

A study of history is revealing to all of us because, while we have been part of it, affected by events and decisions, and sometimes even ourselves effecting actions and changes, we have seldom paused to study the meaning. As Ann Nolte (1981) has recently reminded us, historical research is not simply the recording of events, but is the giving of meaning, or the bringing of understanding to those events. Facts and information are products of a time period and gain significance as they are examined from the perspective of that time period.

This is a personal perspective that, because of the constriction of time, the purposes of this conference, and my own limitations, must necessarily be a restricted one. Nevertheless, it is my hope that this overview may in some sense help to extend your knowledge of our

professional past--to gain new insight and perhaps gain a greater appreciation of those factors that have shaped our programs, our practices, and indeed, are shaping our deliberations this day and in this conference.

My purpose is similar to that expressed by Theodore H. White, the journalist, as stated in his recent book, In Search of History. Having been a witness to and recorder of so much of our recent history, from 1933 to date, he felt the need to try to organize the meaning of these events. He was angry with himself because for so many years he had neither paused nor dug deeply enough to answer the question, "What is it really all about?" He began to think that it was probably more useful to go back and think over previous events than to go on and add new observations. I too hope that this effort to go back and analyze past events will add enlightenment to our deliberations here.

Health education, as a profession, had its birth during and immediately following World War II. Of course, the concept of health promotion is as old as education itself. Many here are aware of the developments during the first decades of this century, when, according to Sally Lucas Jean, the term "health education" was officially adopted in 1918 to describe a new brand of education. This was championed by a newly established group, The Child Health Organization of America. However, health education did not emerge as a special field of study until the 1940s.

To show more graphically the elements that interacted to form this profession, I have prepared the following table, which might be called the "family tree" of health education. As you can see, it consists of two main trunks--community health education and school health education. Giving form and structure to these two areas (or trunks) are eight major events (conferences or reports), listed sequentially, which culminate in the Role Delineation Project of 1981. I would like to utilize this figure to aid in my analysis of those events from 1943 to date, summarizing their contributions and their effects on each other (vertically) and on the total field of health education (horizontally).

COMMUNITY HEALTH		SCHOOL HEALTH
	1980	
1976 SOPHE Guidelines		1976 ASHA Prof. Pref. Report
		1974 AAHPER H.Ed. Competencies
	1970	
1969 APHA - CPE Criteria - Guidelines		1969 AAHPER Certification Standards
1966 SOPHE Statement SCHS PH Health Education		
1964 SOPHE Sub Outline		
		1962 AAHPER-NCATE Format
	1960	
1957 APHA - CPE		
		1953 USOE Second Conference
	1950	
		1950 AAHPER Pere Marquette
		1949 USOE First Conference
1948 APHA - CPE		1948 AAHPER Jackson's Mill
1943 APHA - CPE		

Figure 1. Professional Preparation Developments in Health Education During the Period 1940-1980, Leading up to the Role Delineation Project

First, however, let me refresh your memory of the Role Delineation Project report and its seven major areas of responsibility. This table should provide a backdrop against which an historical view can be developed.

ROLE DELINEATION PROJECT

(7 Areas of Responsibility)

1. Communicating Health & Health Education Needs, Concerns and Resources
2. Determining Appropriate Focus for Health Education (Needs)
3. Planning Health Education Programs/Responses to Needs
4. Implementing Planned Health Education Programs
5. Evaluating Health Education
6. Coordinating Selected Health Education Activities
7. Acting as Resource for Health & Health Education

Figure 2. 7 Broad Areas of Responsibility Common to the Practice of All Health Educators

The discussion of these past conferences and reports then begins with community or public health education, followed by a review of the school health education-related events. Each area is presented in a chronological sequence. At certain points, the standards recommended seem clearly related to earlier developments, while in others, a parallel or contemporary event seems to have exerted a major influence on the form and the substance of the recommended standards. At times developments in the two fields were closely linked, while in other instances, the two fields moved farther apart both in philosophy and in requirements for professional preparation.

The first report to be discussed is the APHA's 1943 statement on health education prepared by the Committee on Professional Education (CPE). Included among the committee members are some familiar names--Clair Turner, Ira Hiscock, and Henry Vaughan. To my knowledge, this was the first APHA statement on qualifications and standards for health educators.

The committee's report included sections characteristic of all of the CPE statements on educational qualifications, such as functions, educational background, and knowledge and skills needed by health educators. While this was a public health education statement, it is of interest to note that considerable emphasis was given to competencies pertaining to the school health programs including teaching methods and curriculum construction.

Five years later the APHA's CPE published its next report, the first one prepared by a subcommittee entitled Health Education. The format was similar to that of the 1943 report listing key functions and educational background. (Emphasis was given to information dissemination functions.) In addition, seven major areas of competency were identified. At the time of this report, there were estimated to be 460 health educators employed in health agencies, with approximately 300 having completed graduate work in schools of public health. Familiar names on this committee included Turner, Bauer, Derryberry, Grout, Morgan, Southworth, and Winslow.

The next CPE report was issued in 1957. Again Dr. Turner served, this time as chairman of the Subcommittee for Health Education, responsible for the preparation of the report. As before, there were similarities between the standards recommended in this report and the one in 1948. However, for the first time, the function of educational evaluation was included. Qualification as a public health educator implied at least one year of graduate education in public health at an appropriate institution. Undergraduate preparation emphasized (1) social science, (2) biological and health sciences, (3) education and educational psychology. The need for health educators was estimated to be between six and seven times the available supply. Others well known to us serving on this committee included Arnold, Lifson, Larimore, and Yoho.

Because there was a real spurt of activity in the mid-1960s, the following reports are considered as a group: the 1964 SOPHE Subject Matter Outline, the 1965 Schools of Public Health/Health Education

Report, and the 1967 SOPHE Statement on Functions and Minimum Requirements for Community Health Educators. These three reports were integrally related in the development of professional standards during the 1960s. SOPHE was a growing influence in this movement, and the similarity of recommendations and standards reflects the participation of a number of the same people.

A comprehensive core of health education competencies were developed that were translated into the recommended standards. Emphasis was placed on theories of attitude and behavior change, communication, education, learning, and group processes. Other areas stressed included community organization, planning, evaluation, and research. The culmination of this activity was the SOPHE Statement on Minimum Requirements, where for the first time, a differentiation was made between the levels of function and knowledge for professionals prepared at the Bachelor's and Master's levels. Ten major areas of function and areas of knowledge were identified, reflecting the previously mentioned health education core. However, it should be noted that this report also included two subject matter content areas: (1) concepts of physical and mental health and (2) health problems.

Actually, the 1969 APHA-CPE Statement is also directly linked to the preceding developments. This report is significant because it, too, represented the culmination of a great deal of activity in the mid-1960s concerning the preparation of community health educators. At this point, those institutions outside the schools of public health evidenced a strong interest in having their community health education programs accredited. Not only was this accredited status important to the placement of their graduates, but institutions also wanted to be able to share in the public health traineeship funds. The problem was that only the schools of public health were accredited and no way existed, at the time, for other institutions to become accredited!

However, a solution was provided when the Public Health Service, under the leadership of Dan Sullivan, contracted with the National Commission on Accrediting, the predecessor to the Council on

Postsecondary Accreditation (COPA), to develop criteria and guidelines for accreditation. The NCA appointed Ralph Boatman as project director. Dr. Boatman had been directly involved with the recent SOPHE statement and had served as chairman of the Schools of Public Health Report on Health Education. In December, 1967, in Washington, D.C., the NCA hosted a national conference as a first step toward implementation of the report. This Commission report included recommendations summarizing all of these recent health education activities, including the previous four reports and the deliberations of the national conference.

SOPHE STATEMENT 1967

Functions and Requirements of Community Health Educators

Of 10 functions listed, they included:

- Participating in Policy Formulation
- Planning & Directing Educational Programs
- Analyzing Community Health Education Needs
- Implementing & Coordination of Programs
- Serving as a Resource in Health Education
- Conducting Staff Development & Training
- Reporting

Knowledge, Concepts, and Skills:

1. Basic Concepts Physical & Mental Health
2. Health Problems & Services
3. Determinants of Behavior
4. Basic Public Health Concepts & Methods
5. Health Education Methods
6. Administration, Supervision & Consultation
7. Program Planning, Implementation & Evaluation

Figure 3. Functions Identified and Areas of Preparation in the 1967 SOPHE Statement that are Reflected in Currently Recommended Standards

The 1969 APHA-CPE criteria and guidelines developed for the preparation of community health educators grew directly from the report submitted to the Public Health Service in 1968. Its criteria not only affected those institutions seeking accreditation for the first time, but also established standards for preparation of all community health education specialists. Marjorie Young chaired the 1969 APHA-CPE Task Force on Health Education. It is noteworthy that she had also served as a member of the steering committee working with Ralph Boatman on the NCA reports.

The 1976 SOPHE Guidelines provides an introductory statement that effectively sets forth the purposes and the methodology of the health education specialist.

> Health education is concerned with the health-related behaviors of people. Therefore, it must take into account the forces that affect those behaviors, and the role of human behavior in the promotion of health and the prevention of disease. As a profession, it uses educational processes to effect change or to reinforce health practices of individuals, families, groups, organizations, communities and larger social systems. Its intent is the generation of health knowledge, the exploration of options for behavior and change and their consequences, and the choices of the action courses open and acceptable to those affected.

The question of standards, certification, and licensure was the central issue, and the decision to use the term "guidelines" apparently was made in order to avoid forcing that issue. The SOPHE report again differentiated between the functions of the baccalaureate and the Master's level professionals. The term "community health educator" was dropped in favor of "health education specialist." Because of the increasing variety of occupational opportunities available, the term "community" was insufficiently inclusive to describe these new roles of the health educator.

Let us now move to the other side of our genealogy and highlight some of the school health developments, starting with the 1948 Jackson's

Mill Conference (AAHPER). Contemporary programs of professional preparation for school health educators originated, to a great extent, with the recommendations arising from this conference. According to Means (1975), this was the first national conference on undergraduate professional preparation for health education to be held in the United States. Here one of the first systematic attempts was made to crystallize the thinking of professional leaders in the formulation of standards and recommendations for the preparation of specialists in health education. Moreover, the conference attempted to determine those elements essential to the preparation of both the classroom teacher and the community health education specialist.

SOPHE GUIDELINES FUNCTIONS 1976

Bachelor's - Master's Level Distinctions

6 Areas

1. Foundations for Health Education
   - Basic Elements Health & Well-Being
   - Contemporary Health Problems
   - Health Aspect of Physical Environment
   - Health Aspect of Psychosocial Environment

(Community - Schools - Health Care - Occupational & Industrial Settings)

2. Administration of Health Education
3. Program Development & Management
4. Research & Evaluation
5. Professional Ethics
6. Special Applications of Health Education

Figure 4. SOPHE 1976 Guidelines Reiterating Earlier Recommendations. New Areas Recognized: Research and Evaluation; Professional Ethics and Special Applications (i.e., School, Community, Patient Education, etc.)

Immediately thereafter, the U.S. Office of Education called its first national meeting in 1949. This conference was unique in that it was devoted exclusively to the problems of health education. One of the highlights of this conference was the recommendation calling for "a common curriculum for the preparation of the public health educator and the school health educator at the undergraduate level." Representatives of both the public health and school health fields supported this proposal. It was also agreed that specialization in these fields should take place during the fifth year of study. Then following in quick succession came the 1950 Pere Marquette Park Conference (AAHPER), which was concerned with graduate study. Its focus was the evaluation of graduate programs and the procedures for accreditation. Much of the current demand for an effectively functioning accreditation procedure stems from this conference.

The Second National Conference on Professional Preparation of Students Majoring in Health Education, sponsored by the U.S. Office of Education, was held in Washington, D.C., in January, 1953. Its areas of concern included both undergraduate and graduate study in health education and matters pertaining to the specialized curriculum of health education. H. F. Kilander was a prime mover in both of the USOE conferences.

Probably the most influential statement coming out of the second national conference was the list of specific courses recommended in a "desirable undergraduate curriculum for the major in health education." The courses were organized under two broad headings: (1) health sciences--personal health, community health, sanitation, nutrition, mental health, family living, home nursing, first aid, safety education, driver education; and (2) professional subject areas--methods and materials, school health administration, school health environment, school health evaluation, and student teaching and field experience. The importance of accreditation was again stressed in pointing out that "the lack of accreditation for institutions preparing school health educators seriously impedes the recruitment, preparation, and placement of qualified personnel." (Creswell, 1964)

SECOND NATIONAL CONFERENCE USOE 1953
UNDERGRADUATE MAJOR HEALTH EDUCATION

Health Science Areas:	Professional Subject Areas:
Personal Health	Methods & Materials
Community Health	School Health Services
Sanitation	Healthful School Environment
Nutrition	School Health Administration
Mental Health	School Health Evaluation
Family Living	Student Teaching & Field Experience
Home Nursing	
First Aid	
Safety Education	
Driver Education, Other	

Figure 5. Areas of Professional Preparation Recommended in this Report, Based on the 1948 Jackson's Mill Conference and the 1948 APHA-CPE Report

The two U.S. Office of Education-sponsored conferences were planned specifically to follow up on the thinking and the planning that took place at the Jackson's Mill and Pere Marquette meetings. The close professional interrelationship that existed in the earlier conferences is clearly evident from the proceedings of this second conference, which reported that the experiences offered by the colleges and universities preparing health educators should include all the competencies recommended by the Jackson's Mill conference and, in addition, should include all of the professional competencies outined in the APHA report on qualifications of community health educators. (Kilander, 1961)

As background to the 1962 National Conference, it should be pointed out that AAHPER had recognized the National Council for Accreditation of Teacher Education (NCATE) in 1960 as its official accrediting agency. This action, coupled with the need to reexamine programs in light of NCATE's standards, led to the development of the National Conference on Profeasional Preparation, held in January, 1962.

How did the 1962 program of apecialization in health education differ from programs recommended by earlier conferences?

1. While the recommendations concerning the basic sciences are quite similar, the delegates to the 1953 conference called for more applied sciences, such as human biology, rather than zoology.

2. The 1962 conference delegates placed greater emphasis on the social sciences, especially those now known as the behavioral sciences.

3. The 1962 conference delegates specified fewer courses but recommended broader course areas. For example, instead of calling for specific courses such as health services and school health environment, the recommendation was for courses in school/community health programs.

In 1969, AAHPER held another conference. This time the focus had shifted from accreditation to the certification of health education teachers for secondary schools. The major concern at this time was the shortage of well-trained teaching personnel. Standards for such teacher certification were recommended, and included (1) general education requirements, (2) biological sciences, (3) physical sciences, (4) the behavioral sciences, and (5) minimum requirements for professional preparation in health education.

A major issue at the time was the need to separate the certification for health education from that for physical education.

The 1974 National Conference on School Health Education resulted from a decision to revise the preparation guidelines developed in 1962. It was unique, first, in regard to the development of extensive pre-conference working papers and, second, by opening the ensuing conference to all members of the profession in order to achieve a democratic, "grass-roots" approach. The basic program design recommended for the curriculum resembled earlier conference decisions, including the following broad categories: (a) general studies, and (b) professional studies.

This conference emphasized accountability, in which recommended standards were written in the form of competency-based and performance-based objectives, representing the extreme position of all preparation conferences in terms of the degree to which standards were written in the form of specific objectives and behaviors.

The final conference to be discussed is the 1976 ASHA Committee on Professional Preparation and College Health Education Conference, which was held at Towson State University. Participants took note of the preceding reports and decided to review the existing documents, select the best parts, and make suggestions for further improvement. The outcome of this conference was a recommended "standarized model" program for professional preparation that was widely disseminated to professionals in the field for review and criticism. The utility of this model program seems to have been demonstrated by its fairly widespread use.

Up to this point I have tried to stick pretty close to the script--that is, a reasonably straightforward accounting of what these conferences and reports were about. Now, in addition to a summation, I should like to add a personal observation or two.

I believe the following list summarizes the major points of agreement relating to these school health education professional preparation conferences.

COMMON AREAS OF PROFESSORIAL PREPARATION
IN SCHOOL HEALTH EDUCATION

1. Foundation Sciences of Physical and Biological Sciences
2. Social and Behavioral Sciences
3. A Common Core of Health Content Courses, Professional Health Education Courses, and
4. The Skills of Professional Practice

Figure 6. Areas Generally Reflecting Recommendations of the Professional Preparation Conferences Held During the 1960s and the 1970s

Figure 7 illustrates the content sections of two of our most recent school health education conferences: the AAHPER 1974 conference, and the Towson State-ASHA 1976 conference. I would like to contrast Figure 7 with Figure 2, depicting the Role Delineation Report and its seven areas of responsibility. To my way of thinking, the issue is one of balance between what I have characterized as a content orientation and a process orientation (see Figure 8).

Conclusion

Upon completing a review of this nature, with its heavy emphasis on fact, one important point may have been obscured. These conferences and reports resulted from the efforts of people. As Theodore White observed, individuals make history. He realized that identities in politics are connected to ideas and that at the core of every great political identity lies an idea that the leader has absorbed, changed, and imposed on others.

So it is in fields other than politics. The profession of health education has been and continues to be influenced by men and women whose identities are connected to ideas. These ideas have created health education and have influenced us in the making of our contributions. We feel a sense of obligation to the leaders and the workers in this field who have gone before us. Many of them because of death, retirement, ill health, or change of responsibility no longer play active leadership roles. I speak of people like Clair Turner, Sally Lucas Jean, Charlie Wilson, Bernice Moss, Mayhew Derryberry, Mabel Rugen, Carl Anderson, Ruth Grout, Beryl Roberts, Del Oberteuffer, Mike Hoyman, Keogh Rasch, Marjorie Young, Kellie Kilander, Tex Byrd, Fred Hein, Dorothy Nyswander, Wally Wesley, Elsa Schneider, Si McNeeley, Ruth Abernathy, Ned Johns, Bob Bowman, Ralph Boatman, Wes Cushman, Warren Southworth, Bob Yoho, and many others. The mentioning of their names causes us to realize anew the magnitude of the legacy and the responsiblity they have given us.

The future is now--the opportunity is here and the challenge is before us--good luck!

CONTENT FOR THE HEALTH TEACHING SPECIALTY

AAHPER 1974	ASHA 1976
1. Environmental Health	1. Peraonal Health
2. Mental Health	2. Community Health
3. Alcohol, Tobacco & Druga	3. Alcohol, Tobacco, & Drugs
4. Nutrition	4. Human Sexuality
5. Communicable & Noncommunicable Diseases	5. Mental/Emotional Health
6. Human Sexuality	6. Ecology/Environment
7. Dental Health	7. Nutrition
8. Physical Fitness	8. Aging
9. Consumer Health	9. Death
10. Community Health	10. First Aid/Emergency Care
11. Accident Prevention	11. Safety
	12. Communicable & Noncommunicable Diseases
	13. Exercise & Fitness
	14. Consumer Health
	15. Dental Health
	16. Health Careers

Figure 7: Health Content Emphasis Characteristic of Professional Preparation for School Health Educators

ISSUE OF BALANCE

CONTENT (Orientation)	PROCESS (Orientation)
1. Environmental Health	1. Epidemiology
2. Mental Health	2. Biostatistics
3. Nutrition	3. Health Services Administration
4. Sexuality	4. Environmental Health (Health Education Perspective)
5. Drugs-Tobacco-Alcohol	5. Communication Theory
6. Consumer Health	6. Communication Techniques (Education Methods)
7. Dental Health	7. Community Organization
8. Concepts of Disease	8. Group Process
9. Physical Fitness	9. Behavior Change Prog.
10. Community Health Problems	10. Learning Theory
11. Accident Prevention	11. Needs Assessment

Figure 8. Content Orientation Characteristic of Professional Preparation in School Health Education and the Process Orientation Characteristic of Preparation in Community Health Education

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The Objectives for the Nation in Disease Prevention and Health Promotion: A Challenge to Health Education Training

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U.S. Department of Health and Human Services

Distinguished deans, fellow professors, and health educators concerned with professional standards: After Dr. Creswell's tour de force of the history of efforts by committees and conferences in the past to address the questions of professional preparation and standards in health education, my purpose at this point is to convince you not to despair at yet another conference; that, in fact, this is a particularly opportune time to have convened once again to address these questions. Dr. Creswell summarized his conclusions with a reference to Theodore White, but what he did, in fact, was to disprove White's thesis that individuals make history. It seems from his report that committees make history. You would be correct if you were to point out that there are few statues of committees in our public parks. But we must nevertheless recognize that committees and conferences are essential to progress and consensus on matters that affect people whose work reflects various perspectives.

The purposes of this conference have been outlined for you from various perspectives. My own concerns as a cosponsor but also as a health educator are to assure that our efforts to delineate the roles of health educators for the future and the tasks of training for health education in the future are properly cast in the context of the national objectives for disease prevention and health promotion. These objectives are themselves the product of considerable consensus-building among various professions and interest groups. I am going to focus in these remarks more on those objectives than on Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention, because for most of you that is by now history. You have seen the

report; most of you have had time not only to read it and to study it but also to share it with your students and to teach some of your courses around it. The copies of Objectives for the Nation that were distributed to you tonight are so hot off the press that the red ink may smear on your hands. Those objectives follow on the Surgeon General's Report; they are the next step in the process of national consensus and policy development in health promotion and disease prevention.

The objectives, as you will note from the material in your packet, are the product of a thorough and systematic process of consensus development across the nation, across professional disciplines, across lay interest groups, and across public and private sector institutions and organizations. All of this consensus has been tempered in the final product by economic realities, political projections, and international comparisons of what should be possible over the coming decade. We have never had, in my view, in concert with our colleagues in other professions, a more specific, concrete, quantified, and widely accepted set of destinations and guideposts for a full decade ahead in disease prevention and health promotion. We have wandered in a wilderness of confusing and sometimes conflicting goals, if we had any at all. Now we have a set of national objectives on who should be expected to achieve how much of what benefits by when. These are not rigid standards; these are not Federal guidelines--they are national guideposts to be adapted to local situations and special population needs. They are not a complete road map--only a set of destinations and markers.

How the Objectives Can Help Delineate Roles

We must decide here at this meeting, I believe, the various paths health education should follow and the vehicles it can offer to empower the public to achieve these ends. Look at the objectives in this document in two ways--first, as a statement of priorities for national attention in order to yield the greatest benefits to the health of the American people. The 15 chapters represent 15 priorities for action to improve the health of the nation (see Table 1). As a set of priorities, they can guide our deliberations here in assuring that we are training

Table 1. Priority Actions for Health from Objectives for the Nation in Disease Prevention and Health Promotion

Preventive Health Services

- High Blood Pressure Control
- Family Planning
- Pregnancy and Infant Health
- Immunization
- Sexually Transmissible Diseases

Health Protection

- Toxic Agent Control
- Occupational Safety and Health
- Accident Prevention and Injury Control
- Fluoridation and Dental Health
- Infectious Agent Control

Health Promotion

- Smoking Reduction.
- Reducing Misuse of Alcohol and Drugs
- Improved Nutrition
- Exercise and Fitness
- Control of Stress and Violent Behavior

health educators for roles that are relevant to the priorities for the nation's health. Second, look at this document as a resource document on suggested prevention and health promotion methods against which the roles, functions, and activities of health educators may be held accountable.

How the Objectives Can Strengthen Health Education Practice

The cycle of poverty of health education programs has been characterized in the past by inadequate support for health education. As a result, goals and methods have been diffuse and of questionable quality. The result has been only modest and scattered impact, and the result of this dilution is that any social benefits have been either missed or undetectable. It has been impossible to make a case persuasively with policy-makers for additional support. And so inadequate

support has perpetuated the cycle of poverty for health education. We have begun to break into that cycle at several levels, particularly with evaluation, as seen in Figure 1.

When a profession or any other enterprise cannot depend on a single source of revenue, it must diversify its portfolio. Health education has had brief periods of greater support from one categorical health concern or another, such as immunization programs in the early sixties, family planning and drug abuse in the late sixties, hypertension in the early seventies, alcohol and smoking in the late seventies. But with these constantly shifting priorities, long-term objectives could not be pursued systematically and diligently. Professional training programs could not keep up with the changing job market and expectations for proficiency in the field. Employers could not count on health educators trained yesterday to understand today's priorities.

THE PROFESSION'S CYCLE OF POVERTY

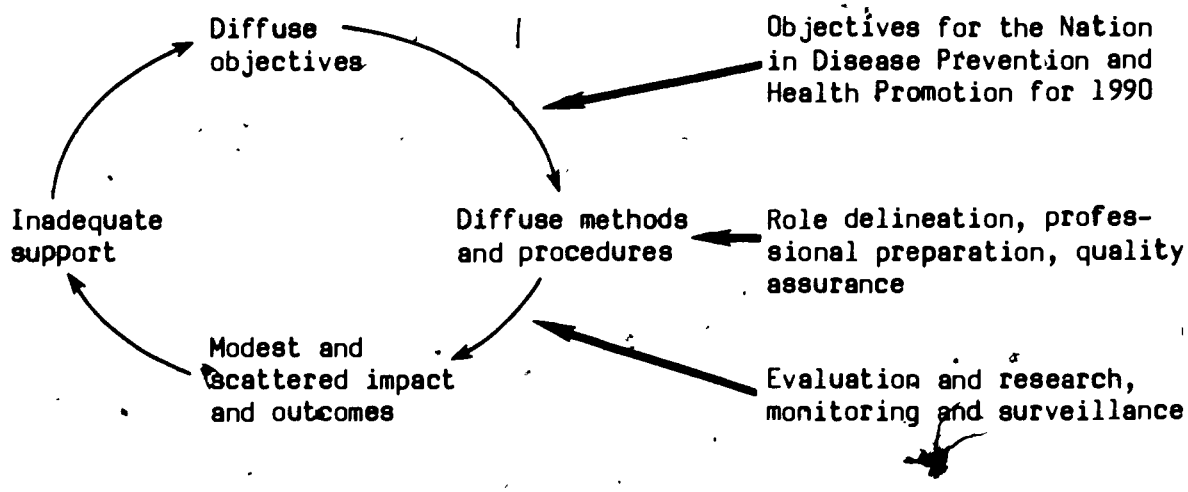

Figure 1. The Cycle of Poverty for Health Education. Here the cycle is redefined to emphasize the points of intervention addressed by current federal policy (adapted from L. W. Green, M. W. Kreuter, S. G. Deeds, and K. B. Partridge, Health Education Planning: A Diagnostic Approach, Palo Alto, California, Mayfield Publishing Company, 1980).

With the 10-year time frame of Objectives for the Nation, we have an opportunity at the beginning of 1981 to plan and focus our professional preparation of health educators on 1990 targets that are diverse enough to assure multiple sources of support, yet specific and distant enough to assure concentration and continuity of our efforts in training and program development.

We have begun to accumulate a literature that assures us that there is an immediate impact of health education that is detectable and significant. We have begun to accumulate some even longer-term evaluations of outcomes, hard outcomes in terms of health benefits. Cost/benefit evaluations have yielded indications that the benefits in health and economic terms outweigh the costs of health education programs. But we continue to slip and slide in this construction of health education's case for more resources because we have failed to articulate our provisions for quality assurance, peer review, and the clarification of the goals, objectives, and methods of practice in health education. That is what we are here to address at this conference, and this is where the Objectives for the Nation in Disease Prevention and Health Promotion can be helpful.

How the Objectives Can Strengthen Public Support for Health Education

There are some other cycles that need to be understood in examining the history and the current status of health education. The decision cycles in health policy and the allocation of resources for health programs can be viewed as overlapping professional decisions and public decisions, as seen in Figure 2. Theory must be translated into policy, and it must be understood by the public that will support policy. Policy is best expressed in the form of objectives. That understanding in the public will result in certain demands and expectations that will influence policy as well as influence practice to the extent that practitioners have direct contact with the public. Practice results in evaluations that build theory, and theory, in turn, can help to build policy and public understanding at another plateau. Where do you fit in that? Where does training fit?

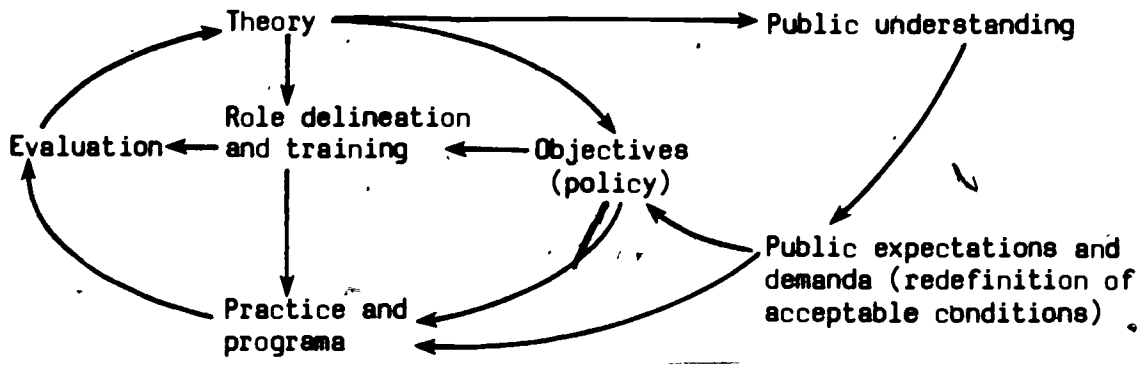

Figure 2. The Overlapping Cycles of Professional Decisions (on the left) and Public Decisions (on the right) (Adapted from L. W. Green, "National Policy in the Promotion of Health," International Journal of Health Education 22:161-168, July-September 1979; and "The Changing State of Science in Health Education," Focal Points, April 1980, pp. 19-23.)

How the Objectives Can Strengthen Profesaional Training in Health Education

Training, it seems to me, is right in the middle of the cycle on the left because theory influences training, policy influences training, training influences practice, and evaluation influences training.

In addressing training at this conference, we have to be concerned simultaneously with these interacting influences of theory and with objective statements of policy, practice, and evaluation, and all the while underatand that public understanding of these things will be necessary to support policy.

One outcome we do not want from role delineation is to mechanize health education practice so much that it will be viewed by the public as a perfunctory, technological process. That is not what objectives are all about. The other thing we do not want to do is to make the goals of health education so monolithic or so unilateral or unidimensional as to make them ill-fitted for large segments of a pluralistic society, imposing majority values on minority populations. We have strived in our development of national implementation plans to consult and incorporate the special concerns of Blacks, Hispanics, Asian

Americans, American Indians, and the elderly. The concept of lifestyle, for example, could be intimidating or oppressive to some people if it were conceived to be a uniform that everyone must wear equally. But we do need to clarify our objectves and roles if we are to be effective and responsible, not to say efficient, in our preparation of professionals for practice in health education. We must understand that our outcomes depend on the quality of our professional practice, which we will determine through professional training and other quality assurance mechanisms. Let me define these terms more sharply for purposes of discussion over the next couple of days.

How the Objectives Can Help in Quality Assurance

Quality I define as the appropriateness of a specific set of professional activities, in our case, educational or administrative activities, as performed in relation to the objectives they were intended to serve. That is what evaluation and theory are particularly about. From evaluation and theory we construct our notions of what are appropriate, specific sets of professional activities in relation to specific objectives.

Quality assurance we can define as accountability for professional activities to someone who needs to know they are appropriately performed. That is where we must strengthen role delineation and the reporting mechanisms that may come out of that, whether it be in the form of credentialing or some other form of reporting or accountability to the public. Quality control is the mechanism or procedure for obtaining quality assurance. This is where monitoring and surveillance, including credentialing, particularly come to rest. Credentialing can be regarded as a quality control mechanism. The specific methods of accountability toward which we might be working for quality control, beyond basic training, might include accreditation, certification, licensure, continuing education, consumer policy committees, and peer review.

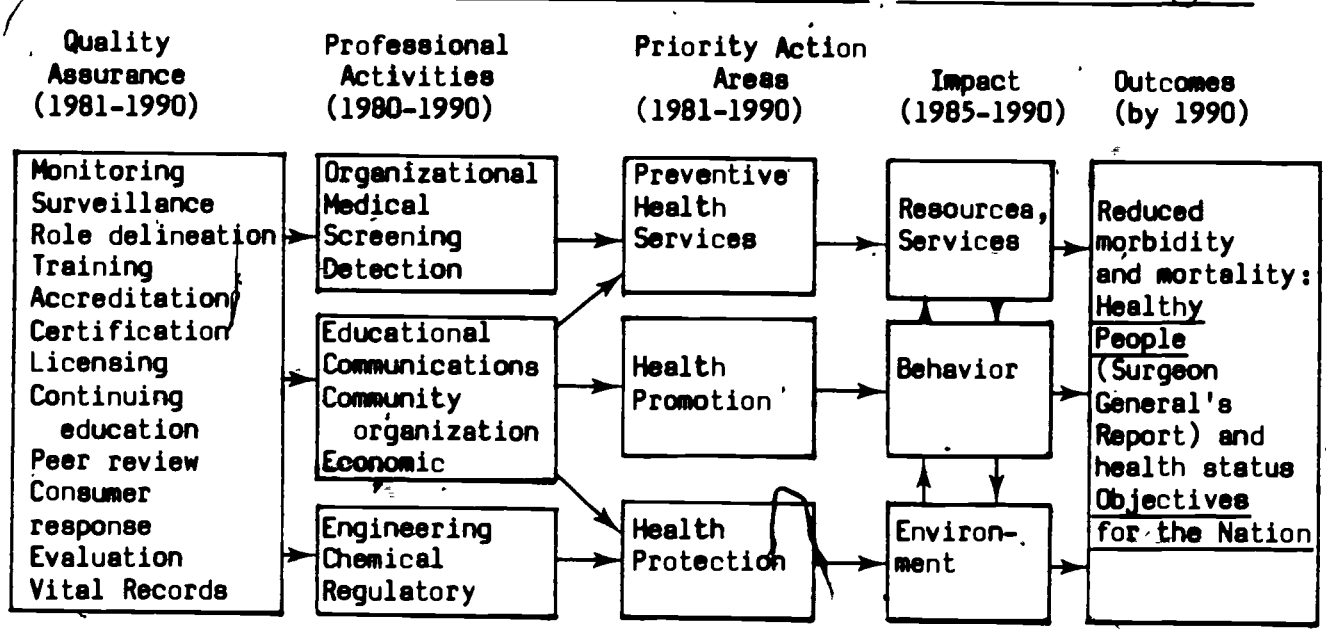

Figure 3. Relationships Among Components of the Federal Initiatives in Disease Prevention and Health Promotion (Adapted from L. W. Green, "Healthy People: The Surgeon General's Report and the Prospects," Chapter 3, in W. J. McNerney, Ed., Working for a Healthier America, Cambridge, Massachusetts, Ballinger Publishing Company, 1980, pp. 95-110; and L. W. Green, R. W. Wilson, and K. G. Bauer, "Objectives for the Nation in Health Promotion and Disease Prevention and Requirements to Measure Our Progress," Proceedings of the 18th National Meeting of the Public Health Conference on Records and Statistics: New Challenges for Vital and Health Records, Washington, D.C., Office of Health Research, Statistics and Technology, NCHS, DHHS Publication No. (PHS)81-1214, December 1980, pp. 229-234.)

How do the three tasks for this conference hang together? There is, first, the task of examining the roles delineated in the July 1980 Focal Points document from the Role Delineation Project. There is the second task of looking for the implications of that document and our recommendations for revision of it, for training, for training institutions, and for students in professional training. Then there is the third task of assuring that all of this relates with some degree of relevance to the Objectives for the Nation as derived from the consensus development process that we have been through in the Federal Government on a national scale with public and private sector involvement.

I would like to take issue with only one definition in the July 1980 Focal Points document that you will be working from, and that is the definition of health education. I do not mean to impose my preference for a definition but just to document my disagreement with the working definition proposed by the Role Delineation Project, which I find unworkable: The definition of health education that I find more workable in relation to quality assurance and role delineation is one that emphasizes the combination of learning experiences designed to support voluntary behavior conducive to health. John Dewey once said that since a democratic society repudiates the principle of external authority, it must find a substitute in voluntary disposition and interest. These can be created only by education. It is in that context that we have the opportunity today to show what education has to offer because the health problems that we are addressing today, as outlined in Objectives for the Nation and the Surgeon General's report, are ones for which more coercive means of behavioral control are not going to be acceptable in this society as were the infectious disease control measures of the past. How does this relate to the broader goals and objectives of disease prevention and health promotion, the third task for the conference?

Structure of the Objectives for the Nation

Health education is one of the many enterprises or technologies contributing to the Objectives for the Nation. Others include political, social, economic, organizational, engineering, and medical interventions. These strategies, including health education as one of the leading methods, are to accomplish objectives in each of the 15 areas of priority broadly grouped under three categories called health promotion, preventive health services, and health protection. The accomplishment of those Objectives for the Nation should achieve the broad goals for the five age groups as outlined in Healthy People, the Surgeon General's Report on Health Promotion and Disease Prevention. The processes that we have been through in arriving at these objectives have included Federal task forces chaired by Dr. Michael McGinnis, Deputy Assistant Secretary for Health, to get the act organized, but

then an increasingly broad-based national consensus development process that led to the publication of Healthy People, and since then the development of the objectives. The objectives grew out of a process of consulting with large numbers of experts and then distributing drafts of the objectives to a wide audience of potentially concerned lay and professional interest groups, organizations, and institutions, public and private. The comments of the three thousand or so individuals and organizations that received the draft objectives were sifted and reconciled and finally put together in the document that you have. Implementation plans are now being developed in each of those 15 areas.

The questions that the implementation plans raise are such questions as Who shall be expected to perform some of the activities necessary to accomplish these objectives? That is why this is not only an important time for us to be addressing this issue, but an opportune time.

Table 1 and Figure 3, as you will note, organize the objectives into three broad groups, preventive health services (related to medical interventions or settings), health protection (related to environmental interventions), and health promotion (related to behavior). The preventive health services, however, contain some objectives that can be accomplished best outside the medical care settings, and health promotion requires organizational and environmental supports for behavior within medical care settings, so that it is not a clear-cut delineation. The objectives relating to sexually transmitted diseases can illustrate the structure, starting with objectives for improved health status. "By 1990, reported gonorrhea incidence should have been reduced to a rate of 280 cases per 100,000 population. In 1979, the reported case rate was 457 per 100,000 population." Each objective is stated in terms of the time by which it should be accomplished, the population who should benefit, and when they should experience that benefit. "By 1990, reported incidence of primary and secondary syphilis should be reduced to a rate of 7 cases per 100,000 population per year, with a reduction in congenital syphilis to 1.5 cases per 100,000 children under one year of

age. (In 1979, the reported incidence of primary and secondary syphilis was 11 cases per 100,000 population, while reported congenital syphilis was 3.7 cases per 100,000 children under one year of age.)"

The behavioral and educational objectives appear not in the category that states the health status objective, as above, but in the next two categories in the hierarchy of objectives that go from improved health status to reduction of risk factors to public and professional awareness. In the risk factor category, there are usually some behaviors that need to change. From there, the hierarchy progresses to objectives related to public and professional awareness, a broad heading that includes a wide range of cognitive phenomena. In that category I think you will find most of the short-run, immediate objectives that health education ought to be accomplishing. In fact, the nation is depending on health education for the accomplishment of these educational objectives, and without their accomplishment we are unlikely to achieve the risk factor reduction objectives and ultimately the health status objectives. Following the public and professional awareness objectives in each chapter are health services and protection activity objectives, and finally a category of objectives for measurement and evaluation, emphasizing increased surveillance and record-keeping systems to enable us to track our progress toward the objectives over the decade.

In addition to the objectives, there is a background prior to each set of the objectives that includes the nature and the extent of the problem, and suggested prevention and promotion measures, prominent among which are information and education measures. For each of the 15 areas, including those in the environmental health protection category, many of the prevention and promotion measures suggested are in fact educational. For every category there are some educational measures suggested in addition to the objectives for behavioral risk factors and public awareness.

Not all of the health status objectives are stated in rates per 100,000 population, but some of them are stated in terms of numbers, as in the case of the incidence of immunizable diseases. For those we are looking toward the near eradication of some of the infectious and communicable diseases. In fact, there is talk today of the possibility of eradicating measles. But I point to this particular set of objectives because it illustrates how some of the objectives associated with preventive health services are going to depend upon schools for their accomplishment. Indeed, we have estimated that approximately one fourth of all the objectives will depend on the cooperation of the education establishment for their accomplishment. If we cannot come to some agreement here among ourselves as health educators, it is unlikely that the rest of the education and health establishment will come to terms on the cooperation of schools and health agencies.

The objectives in the broad category of health protection include those that have to do with the environment, including the workplace environment: toxic agent control, fluoridation of community water supplies, infectious agent control, accidental injury control, and occupational safety and health. These again include a large number of objectives and measures that are educational in character. Half of those in occupational safety and health relate to worker education and the rest to management and professional education.

Then, the last broad category is health promotion, where the objectives fall into five categories--in order of priority, the reduction of smoking, alcohol and drug misuse, nutrition, physical fitness, and stress and violence control. They are in that order of priority because of the state of the art and because of the epidemiological knowledge that those are the things that could make the biggest difference in terms of morbidity and mortality in this country. It is recognized that interventions tend to follow this order of success. But it is acknowledged, on the other hand, that if we could solve the stress problem, we might solve all the others simultaneously.

In every case the Federal questions in developing national policy, as I believe will be the case in developing State and local policy, come down to questions of how we divide the labor among organizations and the health professions to accomplish these objectives. That is the task of role delineation and professional training to be addressed here as we sort out the functions of school, community, and patient education.

Credentialing for the 1980s

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I want to thank you for the opportunity to address you this morning on a topic of paramount importance to each of you and your organizations. The credentialing area in general is one that is frequently misunderstood and one that is often misrepresented.

I've been speaking out on the credentialing issue across the country for a number of years.(13) (14) (15) (16) (17) In many organizations and states, my views are well known. I'm fortunate in that I'm allowed to speak my piece and make my case without necessarily reflecting the views of my employer, New York State. If I am ridden out of town on a rail, I'm on my own. On the other hand, if you like what you hear, they take all the credit for my upbringing. It's a kind of reversal of the old story about the company of college grads during World War II who wouldn't sign up for GI insurance, despite the fact that the battalion had a record of more than 75 percent compliance. After lengthy appeals from the major, the lieutenant, an Ivy League graduate, asked to take a turn. His appeal was based on the need for giving it the old college try--let's give all for the red, white and blue. The compliance rate went up to 20 percent. Finally, an older, wiser noncom came forward and asked to be given a chance to tell it like it is. "Look here, you guys," he began, "let's forget all this junk you've heard and follow me to the bottom line. If you sign up and go and get killed, the government is gonna send your family 10,000 dollars each. If you don't sign and get killed, the brass send your family nothing. Now, if you was the government, who would you send overseas to get killed?"

This morning, I hope to cut through the esoteric jargon and get us to that bottom line, even if it means getting killed along the way.

The whole area of credentialing is no longer in the land of the mystical. Regulatory programs are very much in the public eye, particularly those that are regulated by law.(11) As a group, professional practitioners are no longer a venerated segment of the population.(6) On the contrary, they are more and more frequently being criticized, even attacked, by an increasingly litigious public. Licensing laws are being subjected to sunset legislation in several dozen states, with some licensing boards legislated into oblivion, in some cases for good reason.(9) The message should be loud and clear--a regulatory program, if it is to survive in the years ahead, must be meaningful, necessary, and certainly in the public interest.

Basically, there are two kinds of regulatory program, statutory and voluntary. Let me address statutory credentialing first.

A statutory regulatory program is one that usually comes about as a result of legislative action of some sort, most commonly, an act of a State governing body. In the past, groups comprising mostly members of professional societies lobbied for a regulatory act, which eventually found itself on the books as a State law. However, one of our better-known State legislators told me a few years ago that if most proposals on record today were to be reintroduced now, few, if any, would succeed.

The fundamental reason for regulating an occupation is to provide the public with some degree of protection. If the primary beneficiary of any credentialing scheme is the practitioner, the proposal should never be enacted.(20) Now we all admit that the best proposal designed with the public good in mind will result in potential benefit to practitioners as well, but such benefits must be outweighed by far by the public and societal needs being met.

Regrettably, terms used to describe regulatory programs are neither consistent nor universal. In some instances, the same ones are used, but in different ways, in statutory and voluntary programs. Sometimes our efforts to communicate in the most simple manner lead us astray.

I'm reminded of a recent event during the just-completed census when an investigator sought out an area's old-time resident, having been told that this aged man would have a load of important demographic data at his fingertips. The census-taker asked the man whether he could shed some light on the death rate in his neighborhood. After considerable silent thought, the man said he'd finally figured it out. "I've concluded," he said, "that the death rate in this neighborhood is one per person."

In a statutory credentialing program, the most restrictive, most costly program is one of licensure. Simply stated, in this scheme, a license issued restricts a practice. Frequently, licensure limits the use of certain titles as well, but the primary emphasis in licensure is on restricting practice.(5) For example, a license to practice medicine limits the broad practice of medicine, whatever that is by definition in the law, to a license holder. In most cases, the license also denies those not licensed the use of certain titles. In New York State, for example, only a licensee can claim to be a "physician." Now many non-licensed medical school graduates use the title "doctor," but only a licensee may, under the title "physician," practice medicine.

Another form of statutory regulation is certification, a term also used frequently in voluntary credentialing programs. Again, simply stated, a statutory certification act does not restrict any particular practice, but only the use of a title.(5) There are a variety of examples available. In many states, psychology is a certificated profession, as are professional engineering and, in some cases, social work. While many persons may perform tasks usually identified with psychologists, social workers, or engineers, only persons holding such certificates may use those restricted titles. Now, as if this isn't complicated enough, let me muddy the waters a bit more by referring to some states in which everything issued is called a license, though some licenses restrict practice, whereas others restrict only a title. Despite these few anomalies, however, these dichotomous distinctions hold in most cases. Other forms of statutory regulation of an

occupation exist, the most basic being registration,(5) in which anyone that meets an established set of qualifications may choose to register with the regulatory agency and have his or her name placed on a list of registrants. This process limits neither a practice nor a title, but only provides a list of registrants from among whom the public may choose, should it wish.

This right of the public to choose a practitioner is one now being debated at the highest government levels. A basic question is whether or not government has either the right or the responsibility to restrict practice.(22)

No regulatory program should exist at a level beyond that absolutely necessary to protect the health, safety and welfare of the public. If simple registration will suffice, there can be no justification for licensure or certification. To propose any program, there should be sufficient evidence of need, and detailed data as to why a lesser form is unworkable. Of course, it is axiomatic that even before such data are collected, there must be evidence that absence of regulation of some sort results in recognizable damage to an unsuspecting public.

A voluntary credentialing program is almost universally the function of a state, regional, or national professional association. However, there is no deterrent to a government agency adopting the standards of such a system and incorporating it within its own governance of the state's work force. However, a State may not abrogate its responsibilities for setting minimum standards for entry into a statutory regulatory program, nor may a professional association abrogate that responsibility to itself. However, in a voluntary program, an interdependent relationship between the State and a professional association can and hopefully will develop, wherein standards can be agreed upon mutually, and the purposes of each participant can be accomplished.

Within a voluntary credentialing program, certification can take on meanings quite different from those of the statutory system.(2) A certificate can be more than a single-purpose document. It may signify the meeting of standards for the competent practice of the profession generically, or it may be used to denote specialty qualifications of one sort or another, even excellence in general or specialty practice. Such is certainly not the case with statutory certification in a program. To explain that, let me digress a bit.

In a State-mandated credentialing program, the entry-level license or certificate, or whatever is granted, usually carries with it only a very loose and almost meaningless quality component. It is no assurance of quality or competence.(14) I've heard (and even at times in the past, used) the term "minimum competence." Now, without intending to get into a semantic argument, I find the words "minimum" and "competence" just don't belong together. They remind me of trying to join "slightly" and "pregnant" into something meaningful. George Carlin, in his several lectures on words we use, or shouldn't use, together, has a variety of other examples, many of which I think I won't mention here. It reminds me of the philanderer who justifies his actions by claiming to wear his wedding band only "loosely," failing to accept that a wedding band, no matter how loosely worn, always cuts off circulation.

"Minimum" and "competence" just don't go together. The initial license is a signal to the consumer only that when it was issued, the regulatory agency found the practitioner to be one who could practice safely, not likely to be of potential harm to a client. Now certainly that has a loose quality or competence component, but a guarantee of either quality or competence it is not. Furthermore, once a license has been issued, it cannot be assumed that the level of safety judged at the time of issuance has continued. We are, or at least should be, far beyond that day when we believed that a licensed or credentialed person maintained or improved skills just through daily practice. At one point in time, we were deluded into believing that licensure equaled competence, and that once licensed meant forever competent. That myth must

be dispelled once and for all. Nonetheless, in a statutory program, the determination of what shall be required for entry-level credentialing is a function of the State, usually carried out by the State board for the profession. On the other hand, in a program that is voluntary in nature, the professional society may establish, and usually does set standards for, the issuance of the basic credential. It has been my experience that many voluntary credentialing programs set standards for the entry-level certificate at a level higher than that mandated in a State-regulated system, though such need not necessarily be the case.

The last decade in particular has been notable for attacks on mandatory (that is, State-regulated) programs, coming from a variety of sources.(21) Some have evolved from within the system, from State legislators and other political factions increasingly informed about and wary of abuses by independent, autonomous regulatory bodies, many with parochial self-interests, and frequently without any required review of their procedures and actions by any other governing body. Basic to those attacks, however, are concerns for the program itself, for what is required for licensure or certification, for how standards are applied, and what, if anything, happens to the errant practitioner after that person has entered the system. Regardless of whether a program is statutory or voluntary, standards are standards and should be applied uniformly, and actions that are either arbitrary or capricious are taboo.

The basis for a regulatory program is threefold, encompassing education, experience, and an examination.(13) There should be an identifiable, basic educational program common to all practitioners. A fundamental core of knowledge becomes the hallmark of the science of the profession. Whether or not it can be acquired at a baccalaureate level, amplified through graduate study, or acquired in nontraditional ways or in combinations is less important than the fact that an identifiable educational base exists. Experience, on the other hand, is often of a more variable nature. Some professions have demonstrated that the skills, behaviors, and knowledge required for entry-level practitioners

can be acquired totally within the educational institution, whereas others have not. Only a studied approach to your own situation will result in that determination, but that approach should be undertaken with great care and deliberation, as I intend to discuss further in a few moments. The third component of a viable regulatory program is the examination, the availability of an instrument that allows an applicant to demonstrate possession of the behavior, skills, and knowledge needed to enter practice safely.

In at least one area in the health education field, I know that kind of instrument to be sadly lacking. In school health teaching, for example, I have been unable to find any examination to apply to persons seeking to enter that area of study and employment. In the national teacher examination series, covering, I believe, about 35 area tests, not a single test exists for health educators. A recent study by Dr. Barbara Wilks of the University of Georgia, soon to be published, (23) has identified the many areas wherein potential health educators are required to submit to examinations, but are limited to those designed for other areas, particularly physical education, with a total disregard in the process for any proven relationship, or for that matter, lack of it, between success in phys-ed examinations and school-health education. Not even face-validity concepts would apply here. Interestingly, Wilks found some of these testing requirements to be State-ordered. The fact that school health educators as well as any other professionals require examinations that must be proven relevant to their specialties has not resulted in such requirements, though such constraints have been clearly set by the EEOC, the FTC, and even the U.S. Supreme Court.(9)(21)

Regardless of the profession, whether it be one where we are talking of generic or specialty practice, the examination must be relevant to the task performed by the practitioners.(3) The scoring of the examination too must be free of flaws. The best examination technique is useless if, in its design or scoring mechanism, it fails to identify potentially safe practitioners and to eliminate unsafe ones.(12)

Once these elements have been adopted as essential ingredients in the credentialing program, you must be able to demonstrate that without a doubt, those who have been credentialed and who may practice in an unprofessional manner, or prove to be incompetent despite the efforts to detect them before their credentials are initially issued, will be removed from your midst posthaste. A credentialing program is worthless if strong corrective measures to remove incompetents or others unfit to practice are missing, or even weakly enforced.

Now, let me get back to some of those basic issues I have skimmed over so far.

Without doubt, credentialing confers on its members an occupational identity. Can such an identity exist without an acceptable educational base, one generally agreed upon by all segments of the group identified? The determination of that educational base, and the establishment of a viable accreditation mechanism, are axiomatic. The fact that programs in health education are institutionally accredited is far less important, in my view, than that they lack uniform program accreditation. The very foundation on which a credentialing program in this profession should be built ~~is a voluntary program~~ in which a single, mutually agreed-upon agency appraises the educational offering and measures it against standards set as basic to health education, and grants accredited status to those programs if they are believed to meet those predetermined structure, process, and outcome criteria. That accredited status should be for term, not permanence, and periodic reassessment should be an integral part of the process. Certainly, to reach this fundamental goal, compromises among individuals and groups may be necessary, but you are at the point now where this can and should be accomplished. Without program accreditation, you will have no meaningful credentialing program.

The second question to address is the statutory/voluntary credentialing process. It is my firm belief that you are in a sound position now to move ahead and seek to develop a voluntary certification

program. The mood of the nation today is to limit statutory, restrictive licensing laws, to get government off the backs of the people--as I have stated, for many good reasons. Voluntary credentialing programs are the wave of the future. It is my view that independent, autonomous licensing boards, particularly those resisting some very needed basic structural changes, may be an endangered species. I find it amusing that many profess the desire for progress: It's just change they don't like. Your role delineation study should be finalized, through more and continued widespread exposure and discussion, particularly with the many special-interest groups that exist within the broad field of "health education." Here too, compromises will be necessary to achieve basic definitions regarding roles and titles, but in this sense, you are far ahead of where many other groups seeking regulation are today. Your leadership has wisely taken you into this most difficult self-assessment task at an early point, but considerable work has still to be done, and you must continue to apply measures of self-constraint and not rush ahead without careful deliberation. Unanimity can escape you easily if you're not careful, but at the very least, cohesiveness is important, particularly in such a vast, complex, and often overlapping field.

A variety of options are open to you. The first to consider is the "entry-level" credential. Should it be generic, something like "certified health educator," with specialization left to different-level certificates? If it is agreed that there is a common educational core for all health educators, a generic-level certificate may well suffice. This can be followed by specialty certificates denoting qualification in more restrictive areas of expertise, each requiring a level of skill beyond that of the beginning practitioner. Now "beyond" in this sense doesn't necessarily connote "better" or "higher," but possibly only "broader." The differences may be only horizontal. In addition to that specialty certificate may be one that denotes "excellence," and it is my belief that the consuming public is in a state of readiness now to accept a well-planned, sort of "cradle-to-grave" program. What I'm proposing to you now doesn't generally exist, though that lack is more the result of some disdain for change, a sort of "take-it-or-leave-it"

attitude, on the one hand, by some existing programs, and an earnest desire to do something different, constructive, and more meaningful than what has been done in the past by new groups such as yours, on the other hand, with progress understandably slow.

I'm particularly impressed by the basic fact that you are educators--education is your product, it is your strength. It is what you have to sell, so let's consider doing just that--educate!

What I propose you consider is, above all, a major task--it will require a lot of discussion, possible argument, compromise certainly, but you have the potential for a model for all of the health field.

- First of all, re-look at your role delineation study. Is it addressing what actually is health education today, or does it address what you have decided is the ideal for health education? You can't have it both ways unless you are that rare group (which I don't believe exists) wherein the actual practices of today are those considered ideal for the field. Separate those practices found in your study that exist today and are not the ideal and identify how you intend to educate your newcomers to eliminate those and how your educational programs will require change to assure that your ideal or something near it will be reached in a reasonable time frame. Study your task analysis carefully. There's a lot of difference between a study that addresses the practice ideal and one that refers to what is happening now, or one that unknowingly mixes the two. Several professions, most notably nursing, have found that serious role discrepancies and differences in role conceptions in a task analysis can seriously affect a certification program. A 1976 study by Dr. Barbara Pieta of the University of North Florida has reflected on how holding power in a profession, among other critical things, can be markedly affected if you aren't certain about your identification as "ideal" or "actual."(10)

- In your case, and at this point, consider building your certification program for the future, for what the ideal practice of health

education should be. Consider modifying the educational programs so that at whatever time frame you set, they will provide graduates with acquired knowledge, skills, and behaviors paralleling your ideal.

Within a voluntary certification program, provide for a generic certificate that signifies to anyone who is interested that this is a competent practitioner. Allow that other level, the "safe" practitioner, to a State regulatory program, if a State wants one. Offer specialty certification, in addition, to the competent certificant who wants to display special training in, let's say, school, community, or public health--or whatever other specialty you may find meaningful. Finally, at the pinnacle, consider offering a certificate of excellence denoting that the holder has given evidence of being an outstanding practitioner in the health education field, regardless of specialty.

Fundamental to this system are three elements:

The first is that each certificate be based on requirements drawn from your role delineation study, and clearly show that the certificant possesses the behaviors, skills, and knowledge essential to that level of practice.

The second is that the certificate not be granted forever, that something be expected of the certificant to guarantee that competence after initial certification will be continued. Now, in this regard I'm referring to the need for measures of continued competence.(6)(7)(19) Continuing education has failed to provide such assurances. Professor Houle(6) has characterized the continuing education movement as one "...born out of an eager directiveness and naive faith...." He has further stated that "...this mandatory continuing education phenomenon is an ever-expanding balloon that is becoming increasingly difficult to manage and on the verge of exploding." I am in complete concurrence with the view of Professor Houle and others that the "enrollment criterion" as a measure of continued competence doesn't work. A colleague of mine, in describing adjudicated cases of malpractice in the health

professions, said he knew of none in which the practitioner was found guilty as a result of a lack of knowledge.

The third element is that the entire profession embark on an ambitious public education program to inform consumers of how important it is to seek out the services of a certified practitioner. This is the major educational task I referred to when I suggested you use your educational expertise. Consumers are not as ignorant as some would like to think they are when it comes to contracting for professional services or learning how best to do that. I am a believer in Friedman's 1962(4) observation that:

> "If the argument is that we are too ignorant to judge good practitioners, all that is needed is to make the relevant information available. If, in full knowledge, we still want to go to someone who is not certified, that is our business; we cannot complain that we did not have the information."

Finally, I'd like to use a story once told by Dr. Alexander Calandra,(1) to demonstrate how easily the demand for critical thinking can lead us astray:

> It seems that Calandra some time ago received a call from a colleague who asked him to be the referee on the grading of an examination question. His colleague was about to give a student a zero for his answer to a physics question, while the student claimed he should receive a perfect score and would do so if the system were not set up against the student. The instructor and the student agreed to submit this to an impartial arbiter, and Calandra was selected. He went to his colleague's office and read the examination question, which was, "Show how it is possible to determine the height of a tall building with the aid of a barometer." The student's answer was, "Take the barometer to the top of the building, attach a long rope to it, lower the barometer to the street, and then bring it up, measuring the length of the rope. The length of the rope is the height of the building." Now, this is a very interesting answer, but should the student get credit for it? Calandra pointed out that the student really had a strong case for full credit, since he had answered the question completely and correctly. On the other hand, if full credit were given, it could well contribute to a high grade for the student in his physics

course. A high grade is supposed to certify that the student knows some physics, but the answer to the question did not confirm this. With this in mind, Calandra suggested that the student have another try at answering the question. He was not surprised that his colleague agreed to this, but was surprised that the student did.

Acting in terms of the agreement, they gave the student six minutes to answer the question, with the warning that the answer should show some knowledge of physics. At the end of five minutes, he had not written anything. Calandra asked whether he wished to give up, since he had another class to take care of, but the student said no, he was not giving up. He had many answers to this problem: He was just thinking of the best one. Calandra excused himself for interrupting him, and asked him to please go on. In the next minute, he dashed off his answer, which was: "Take the barometer to the top of the building and lean over the edge of the roof. Drop the barometer, timing its fall with a stopwatch. Then, using the formula, S = 1/2 AT squared, calculate the height of the building."

At this point, Calandra asked his colleague whether he would give up. The colleague conceded. In leaving his colleague's office, Calandra recalled that the student had said he had other answers to the problem, so he asked him what they were. "Oh, yes," said the student. "There are many ways of getting the height of a tall building with the aid of a barometer. For example, you could take the barometer out on a sunny day and measure the height of the barometer, the length of its shadow, and the length of the shadow of the building, and by the use of simple proportion, determine the height of the building." "Fine, and the others?"

"Yes," said the student. "There is a very basic measurement method that you will like. In this method, you take the barometer and begin to walk up the stairs. As you climb the stairs, you mark off the length of the barometer along the wall. You then count the number of marks, and this will give you the height of the building in barometer units. A very direct method. Of course, if you want a more sophisticated method, you can tie the barometer to the end of a string, swing it as a pendulum, and determine the value of 'G' at the street level and at the top of the building. From the difference between the two values of 'G,' the height of the building can, in principle, be calculated."

Finally he concluded, "If you don't limit me to physics solutions to this problem, there are many other answers, such as the best one. That is taking the barometer to the basement and using it to knock on the superintendent's door.

When the superintendent answers, you speak to him as follows: 'Dear Mr. Superintendent, here I have a very fine barometer. If you will tell me the height of this building, I will give you this damn barometer.'"

I think an essential lesson lies somewhere between this story and the issues I raised with you this morning. For the most part, I have tried to set the stage for the sessions to follow and for the deliberations necessary in the months ahead as you work toward the development of a certification program. Wherever possible, I have dealt in generalities. The list of specifics, however, is lengthy, complex, almost unending, yet not overwhelming. It includes such things as:

- Developing a sense of perspective, where you really want to go
- Identifying an appropriate program accreditation agency
- Putting together the concepts of a licensing examination
- Developing an RFP for test service agencies...and so on.

As you undertake these tasks, you are going to need to talk, confer, maybe even argue with those of us who have already "been there." After all, there is nothing to be gained in spending time and money "rediscovering the wheel." Unfortunately, there are many self-proclaimed experts in this area, but a smaller number of us that have spent most of our professional lives "with the troops" and who have been a part of the exciting changes now taking place in credentialing. For example, we have seen and participated in the development of the National Commission for Health Certifying Agencies, an organization that I believe will ultimately prove to be a key to the future success of the voluntary credentialing programs in the health area and one that has education of leaders of health occupations as a major goal.

Those of us who believe in credentialing and who are dedicated to the betterment of the system are always available to you as the need arises, but like Calandra's student, you must be the masters of your own

critical thinking. During these next few days and in the months that follow, I can only encourage you to take heed of what you have heard; consider the critical points; try to put the pieces together that are meaningful to you, in whatever fashion you decide is most suitable for your organization; and do so in a common-sense manner. Feel free to ask questions, talk to us as you need to, then collectively and through the governance of your association, make your own choices, hopefully in such a manner that rapid changes can be accomplished to meet changing demands as they may occur in your own situation. We are here to help, to advise, but <u>your</u> role is to make the decisions.

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Perspectives on Role Delineation

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The purpose of this presentation is to address some of the significant features of the development of the initial role delineation document and ongoing activities of the Role Delineation Project. As can be seen from the other presentations made at this conference, the Project shares a broad historical base in professional preparation that covers many decades. In turn, the Project's activities are pointed toward developing a consistent and broadly based system for assuring that health educators are in a position to contribute to furthering the maintenance and improvement of the health of the public for the immediate and long-term future. Credentialing systems present difficult challenges to the profession; yet they can enhance the delivery of better health education services to the publics we serve.

For more than two years, the role of practicing health educators working in community, medical care, school and other settings has come under intense scrutiny. Through the Role Delineation Project, consistent with past efforts, the current investigation is pointed toward systematic strengthening and improvement of the preparation and practice of health education specialists. Yet the Role Delineation Project, in its organization and processes, is different from these past attempts.

For example, support for the current effort is significantly different from that for past studies. In this case, the Division of Associated Health Professionals, part of the Health Resource Administration's Bureau of Health Professionals, DHHS, has contracted with the National Center for Health Education to conduct the study. The Center, a nonprofit educational corporation that evolved from one of the principal recommendations of President Nixon's Committee on Health Education, functions independently of the professional associations to which

health educators belong. The Division of Associated Health Professions' contract activities in role delineation studies are a derivative of Congressional legislation that seeks to assure the public a basic level of quality for services rendered by allied health professionals. As a consequence, a number of health professionals, in various stages of professional development, have undertaken role delineation studies. As part of the contract requirements, it is incumbent upon the contractor and those directly involved in the Project to include all facets of professional practice as part of role delineation activities. Continuation of Federal support for each phase of the Project is contingent upon successful completion of each contract, acceptance of each contract's outcomes by the profession as represented on the Project's Advisory Committee, and ongoing availability of Federal funding.

The Project's Advisory Committee is made up of representatives of eight national health education organizations plus representatives of consumer and employer interests, and of health education in medical care settings. The National Task Force members, who initiated the Role Delineation Project, serve on the Advisory Committee in their roles as representatives of the professional associations. Thus there is a broad scope of representation of various interests involved in the preparation and practice of health educators.

Another novel aspect of the Role Delineation Project is its concentration upon the role of the entry-level practitioner. As part of the Congressional mandate that resulted in role delineation studies, the focus is upon basic levels of quality for services rendered by health professionals. Other professions have established a wide range of methods to ascertain basic or entry level. Among the various criteria are most often one or more of the following: educational attainment, a period of supervised field experience following graduation, and examinations administered to certify or license individual practitioners on a voluntary or mandatory basis.

Identifying the point of entry into the profession has proven to be among the more troublesome areas for other professions in different ways. For example, the American Physical Therapy Association has called for elevating entry level into physical therapy to the Master's degree level by 1990. This has implications not only for current practitioners, but for student/consumers, educational institutions, employers, third-party payers, and public policy makers. Ultimately, the public will bear the brunt of such professional decisions. For health educators, care must be given to establishing one or more entry levels for the profession. The intitial definition of entry level at the baccalaureate level must be carefully examined against the field of practice.

The focus on entry-level, or basic level, preparation leaves open a great many unanswered questions. If we can delineate the role(s) of entry-level health educators, what is the role of an advanced-level health educator? What do employers expect of entry-level practitioners? Will one role for an entry-level practitioner be sufficient to include all of the practice settings in which health educators are found? Is there only one level of entry into the profession? Are we talking about entry as a professional health educator, or are we talking about entry into specific settings? Answers to these questions may be found in surveying the field of practice, a survey which the National Center for Health Education will conduct as a companion to our current role delineation activities.

Another facet of the entry-level question revolves around the necessity for supervision. Those participating in the initial phase of the Project observed that while entry-level health educators should be supervised, such is often not the case. Undoubtedly, this situation contributes to an erosion of professional identity early in the career of any health educator. Reinforcement through peers or colleagues is often inadequate or absent. Coupled with an acknowledged deficiency in the field of a network of continuing education programs, this weakens an already ill-defined professional identity for health educators. Even experienced and capable health educators are often repeatedly asked to

justify or define health education for their employing organizations. How often must the field and the profession be defined and redefined? Admittedly, we are in a rapidly evolving field that is gathering itself together, both as a profession and in skills offered.

In addition to the funding and organizational support, focus on entry level, and supervision of health educators, the basis for the development of the initial role differs widely from past efforts. A cursory review of the preparation statements developed by the various associations reveals that they were developed in a manner that suited the purposes of each organization. That is, school health education statements on preparation reflected the interests of school health educators, and, in a similar fashion, public or community health education statements were prepared to meet the needs of the sponsoring organizations. With all of the organizations represented on the Project's Advisory Committee and the Federal Government providing fiscal sponsorship, it became impossible for the initial role specification to be couched in a way that reflected a dominance by any one association.

Early in the initial phase, one of the first decisions was to attempt to describe a common entry-level role for all health education practitioners. The decision was based upon a careful analysis of the proceedings of the Bethesda Conference (1) that preceded the Project. As part of the proceedings, the participants envisioned circles of functions that overlapped among school, community, and medical care settings. In the center of the three overlapping circles was a shaded area that reflected functions shared by health educators in all three work settings. The Project's Working Committee hypothesized that the shaded area of common functions was much larger than that depicted.

Among the difficult tasks in developing a common, or generic, role was the selection of terminology that would be commonly accepted and understood by health educators in all settings. No such terminology existed in the profession. This had the hazard of potentially rendering

the initial role specification meaningless to the constituency for whom it was intended. In spite of the obstacles presented, the initial role specification contains language that was mutally acceptable to those involved in the Project from various preparation, practice, and professional association backgrounds. This was accomplished by using consensus as the principal decision-making process.

As a consequence, production of the initial role specification required six meetings of the Project's Working Committee in less than a year's time. Much of the time spent in meetings was devoted to testing proposed role content not only for its relevance to practice but also for acceptability of the terms selected. The result was determined to be representative of the field of practice.

In addition to the proceedings of the Bethesda Conference, staff and the Working Committee based the initial role specification upon a wide variety of available resources. First, staff solicited and collected job descriptions from health educators wherever they could be found. Over six hundred were accumulated. Of those, more than three hundred were analyzed and compared to the drafts of the role specification in order to inaure comprehensiveness. Thus the perspective of employers was included in the initial role specification.

Second, professional preparation guidelines from the various professional associations were collected and scrutinized. This assisted in selection of both content and language. Also, the literature of health education regarding preparation and practice found in journal articles, conference reports, and special publications was used. Thus the perspective of the profession was included in development of the initial role specification.

Third, many descriptions of professional preparation were gathered or made available during the course of the initial phase of the Project. These materials were useful in determining the "fit" of the role specification with the wide variety of professional preparation curricula.

Bear in mind that there have been more than 270 college and university programs of professional preparation identified across the country. As has already been noted, without a common focus for preparation, the curricula vary widely. Thus the perspective of the professional preparation programs was included as an additional factor in the course of developing the initial role specification.

Tying these perspectives together was the Role Delineation Working Committee, reflecting a diversity in preparation, professional experience, and professional affiliation. In their deliberations, both at meetings and in between, the committee members sorted through the accumulated materials, made comparisons, and evaluated the relevance of the collected data to the task at hand. Distilling the collected data through the various perspectives of the committee members resulted in the development of the initial role specification.

One other, and significant, deviation of this effort from past efforts in health education is the basis upon which the content is developed. While the content comes from the profession of health education, the format for the role specification is based upon the current concepts of criterion-referenced testing. As the other speakers will attest, a credentialing system for health education, or for any other profession for that matter, must be based upon the skills and knowledge that are indicative of successful, or at least acceptable, performance on the job. This is a significant departure from traditional credentialing practices. In the past, credentialing systems have relied heavily upon the standards of each profession in question.

Because of renewed interest in accountability of the professions and other social institutions, an examination of the association between professional standards espoused by professional associations and the need for protection of the public has evoked a strong suspicion that a significant gap exists between professional interests and the need for protection of the public against incompetence. Much of the focus of this concern is at the level of credentialing mechanisms, most notably

licensure among the States. While this appears to be separate from professional preparation concerns, experience and the literature point to the frequent association of educational attainment and licensure of individuals as a continuous process. For example, in medicine, graduation from an accredited school of medicine is a prerequisite for taking a licensing examination.

A remedy for the difference between public need and professional standards has been found in criterion-referenced testing. As first identified by Glaser in 1963, (2) criterion-referenced testing uses a standard of success based upon objective measures to gauge the capabilities of particular individuals. This is in contrast to traditional testing practices that attempt to determine an individual's status by some measure in relation to other individuals. Since 1963, numerous technologies have been introduced and refined to more fully develop and extend Glaser's original concept. These technologies are rapidly being implemented in the professions and business and industry as well as in education.

Popham, in his book, Criterion-Referenced Measurement, (3) depicts the basis for successful development of any criterion-referenced test as an explicit and complete description of behaviors that are essential to competent practice for any individual. It is essential, first, to identify the object that is to be tested. In this instance, it is the profession of health education. Competencies, in this usage, refers to behaviors that have been determined to be essential to acceptable performance of a service to society. Role delineation is the process used to determine essential competencies, which includes the identification of requisite skills and knowledge.

The Bureau of Health Professions has developed an outline of the credentialing program it sponsors. There are four phases of the process: Phase I--Role Delineation, Phase II--Resources Development, Phase III--Examination Development, Phase IV--Examination Administration.(4) For health education, we are currently involved in the first

phase. Initial role delineation has been completed, and role refinement and verification are currently under way. Once the role delineation phase is complete, the profession will be in a position to develop a mechanism to begin the process of developing a comprehensive credentialing system for health educators.

The first part of role delineation is intended to give a rough estimate of the field of practice for a particular profession. The sources cited above for the initial effort come from the available literature and expertise in the field.

The second part of role delineation comprises a major effort to refine the initial role delineation through tapping the experiences of practitioners in the field. For health education, this has meant using the initial role specification as a tool to interview practicing health educators so that revisions can be made to make delineation more parallel to practice. Subsequently, the revised delineation is being used to develop an instrument to be administered by the National Center for Health Education as part of a survey of practitioners. The data from practitioners will be used as the primary source for restructuring the role delineation to reflect the essential major and specific responsibilities of entry-level health educators. Included in the final product of the refinement and verification study are the skills and knowledge necessary for performing the role. Such skills and knowledge will be weighted according to their relative importance to practice in the various settings in which health educators work.

In addition to determining responsibilities and skills and knowledge, refinement and verification will identify one or more entry levels to the profession, ascertain the conditions of supervision under which health educators work, and determine the existence of a generic, or common, role for health educators at the entry level. The final product of refinement and verification will reflect the judgments of experts in the field, the literature of the profession, the perspective of employers expressed through job descriptions, interviews with practicing

health educators, a national survey, national workshops, round-table discussions, expressions from concerned individuals, and deliberations by two working committees and the Project's Advisory Committee.

The final product will be useful for carrying out subsequent role delineation processes in the other three phases. Yet the real decisions are left to the profession. Role delineation is designed to allow the health education profession to determine whether a credentialing system can be designed that is responsive to the needs of the public and useful to employers, public policy makers, and the profession. Once refinement and verification are completed, the development of educational resources and credentialing examinations will shift the burden of responsibility for developing implementation mechanisms from government-sponsored activities to the organization of the profession to meet the requirements of credentialing from pre-service education to continuing professional development.

Following refinement and verification, it is an essential first step in basic quality assurance to develop and disseminate curricular guides to help strengthen professional preparation as a forerunner of all other credentialing mechanisms. If, for example, the profession moves toward a certification program (generally, a voluntary effort using national standards in a qualifying examination); then it is essential that there be a core of health educators prepared who are eligible to demonstrate successfully their mastery of essential skills and knowledge. In addition, other devices, such as self-assessment documents and continuing education materials designed for practitioners currently working in the field, should be developed to strengthen practice and provide a basis for continuing professional development programs. This will assist those in the field to demonstrate successfully their proficiency in the skills and knowledge reflected in the certification examination. Also, to carry the example through, such self-assessment mechanisms and continuing competency materials would provide an opportunity to those who come into health education from alternative routes to develop their health education skills to a level

of proficiency consistent with the demands of basic quality as reflected in the certification examination.

As a final note, it should be recognized that role delineation provides the profession of health education with a process for the profession to determine its future. The process is a continuous one. The difficult first step is being completed. Improvements can be made during subsequent phases. New theory, discoveries from practice, research, demonstration, and the influence of the forces governing society can be systematically incorporated into the practice and preparation of health educators by retaining a process useful to professional growth.

As a result, consumers and employers will be in a better position to evaluate the services of health educators. Public policy makers will be in a position to knowingly allocate limited resources to the preparation and continuing professional development of health education personnel. Third-party payers will be able to establish meaningful standards for compensation for health education services, and the professional health educator will benefit from having marketable skills applicable to a wide variety of settings, with a career ladder and a sense of professional pride and responsibility.

The role of health educators is clear in Objectives for the Nation. But the time is short. In order to meet the challenge of effective and comprehensive health education in all aspects of society, the profession has little time for inaction. The objectives are meant to be attained by 1990. Through role delineation and the commitment of dedicated professionals, the challenge can be met.

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Implications of Credentialing's Importance for Community Health Educators

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Alfred North Whitehead has said that "[e]ducation is a setting in order of a ferment already stirring in the mind." Part of my task this morning is to assist in creating this ferment. Perhaps there is a need to stand back from the immediate problem of credentialing and to examine what is happening within the field of public health and within our own profession, and to make some judgments about how we should react to those situations. There is need to understand our relationships within health services and our relationship to the social, environmental, and health problems of the nation. Within this relationship of health education to the health problems of the nation, we should find the reasons for our concern with credentialing.

We should heed the advice of Gordon Allport, who warned of "the functional autonomy of motives." While we may all be deeply concerned with the need for credentialing, we must keep in mind that credentialing is an instrument. We need to be clear as to the purpose of the instrument, the usefulness of the instrument, and the acceptability of the instrument to the profession of the future.

It is a matter of some surprise to find that everyone is a health educator. Those holding M.S.W.s claim to be health educators; those with M.S.s, M.A.s, M.H.A.s, or M.P.H.s in planning--all claim to be health educators; almost without exception psychologists in public health claim to be health educators, whether their backgrounds be in clinical or social psychology; and there is even one woman of my acquaintance who majored in Classical Greek. I wonder, do we have a tiger by the tail?

As a national group of concerned academics charged with the responsibility of providing the competencies and skills that define the health education profession, we need to define our purpose or goal. This seems to be an essential first step in the process of defining roles. I would suggest three possible purposes for universities offering community health education programs.

Some may be concerned with the visibility of health education within the service structure of public health without particular concern for the methodology or professional role associated with such a service. A second possible definition of purpose might be the methodological area. Some may be concerned with providing the competencies and skills necessary to the efficient and effective health education of the public without particular concern for the professional identity of those who provide the education. A third definition of the purpose of an academic program in health education is the preparation of an exclusive group of people within the health sciences known as health educators. Presumably there is a body of knowledge and skills that define the profession. If we are to prepare, at the baccalaureate or Master's level, people called health educators, what are the essential competencies and skills without which a health educator is a charletan and a quack? This is an essential question for the profession.

Our professional concern with entry-level preparation has coincided with a strong public demand for baccalaureate programs in health education. Universities have responded quickly to this demand, and my most recent information indicates at least two hundred university programs offering health education at the undergraduate level. There is no accurate figure for the number of people who are granted baccalaureate degrees in health education each year. My uninformed guess would be 2,000.

But there is no uniformity in this degree. Some degree of uniformity seems to be important if we are to consider certification or accreditation. Agreement on such uniformity will be difficult. Many

health education faculty have had no formal or informal exposure to the theory or practice of health education. Many come with biology, social science, or physical education backgrounds; and it seems difficult, if not impossible, to define a common body of knowledge within a university setting that may provide a professional base diverse from leadership within the university setting.

There is a further question of leadership within the programmatic area of community health education. For at least a decade there has been a large surplus of psychologists in the United States. This surplus will be accentuated in the coming decade. Furthermore, health manpower projections indicate a surplus of between 60,000 and 90,000 physicians by the year 1990. The impact of this surplus is already reflected in the number of physicians who are moving into the health education field. On the one hand, we have a large group of undergraduates with no uniform preparation, all claiming some skills and competencies in health education; and on the other hand, there is a large surplus of behavioral scientists and physicians interested in accepting leadership posts in health education. Many health education projects are directed by non-health educators and are staffed by people who wear the label of health education, but have few skills and little academic training in community health education. Is credentialing going to affect this situation?

The current emphasis on the entry-level health educator raises another question. What is the impact of our current concern and activity on the M.P.H. degree in health education? The SOPHE document on guidelines to the preparation and practice of health education provides our best current guide to standards. Any partial review of this document would suggest that the Master's degree is similar in almost every respect to the Bachelor's degree. This is confirmed in the role delineation document. There is no clear differentiation of skills, only a little more of the same. Particularly in the current era of economic stringency, perhaps we, as a profession, are contributing to the weakening of the professional category of the M.P.H. by our emphasis

on the wide range of skills and competencies delineated for the baccalaureate. Is this what we intend? While focusing on the standards for entry level, we must remain conscious of the total system and the impact of our efforts within that system.

Health educators have never been more fortunate in the resources available to them. The last decade has seen the establishment of two national offices, both of which have, in a short time and with comparatively slender resources, given fantastic support to the profession. We have a National Center for Health Education, highly active and privately funded. We have a large body of research, growing almost daily, that confirms the close association between the habits of people in their social and physical environments and the kinds of morbidity and mortality to which they are subject.

We have received in the last two years from the Surgeon General's office two volumes that support the whole concept of health education, and I speak here of two books, Healthy People and Promoting Health/ Preventing Disease. One calls for a second revolution in public health and provides feasible targets with particular emphasis on behaviorist aspects of health. Implicit in this publication is a challenge to health educators to provide leadership in this revolution toward new levels of health and a better quality of life. The second publication goes a long way toward laying out a health policy for the nation and emphasizes in this policy statement the concepts of health education and health promotion.

In the last year Larry Green and Helen Ross, with their co-authors, have provided us with two superb textbooks, thus offering the possibility of uniformity in teaching health education. The National Center for Health Services Research recently has issued RFPs on health promotion and disease prevention for the second time in less than six months. We have never had it so good.

Furthermore, and most important, the concept of health promotion has been separated from that of medical care by the Federal Government, and has thereby provided us with a firm professional platform. We have developed our guidelines, and the role delineation study is complete. These are big steps. But we are still a long way from professional monitoring.

In conclusion, I would like to bring up two further issues that have serious implications for community health education.

The first of these is constituency building. Ray Salman has told us to get out there and educate our public. While one or two of our members have outstanding records in building constituencies in the states, or at the national level, most of us have been content to be bureaucrats and to neglect or even avoid the task of constituency building. In our current cultural and political climate, we neglect constituency building at great risk. We must work to develop networks in our states and at the national level that provide visibility along with political and professional support. This seems essential to credentialing and to a professional identity.

My concluding point, one that supersedes all points I have tried to make, is the need for solidarity, to use a current term. Many professions in their adolescent stages go through fragmentation. This is but a reflection of diverse viewpoints and areas of specialization. In health education we are passing from adolescence to maturity. We now require specialization without fragmentation. We have at least six different organizations, each defending its own turf and claiming its own exclusiveness. Professionally this is suicidal. For too long the rift between school health educators and community health educators has been seen as a chasm, whereas in reality, it is little more than a ditch.

There is need for school health educators to extend their vision beyond the classroom to include the whole school system of teachers,

administrators, and parent groups. There is a concurrent need for the community health educator to recognize the strength of the school health educator and the powerful intervention modality that the school represents in our society. The situation does not call for a strengthening of coalitions but rather the abolition of petty fiefdoms and a consolidation of the profession into one professional organization. Specialization is essential and must take place, but must be built on a uniform body of knowledge, as in law or medicine.

In summary, can we define for ourselves a sense of our goals in professional preparation? Are we building on a philosophy of human relationships, or are we looking for a set of competencies? Are we working toward the strengthening of the "open society" concept of the independence and interdependence of people within their families and within their communities? Can we develop a consensus about the philosophy, competencies and skills that are the strength and distinguishing features of those who are proud to be called health educators?

Concerns About Credentialing Health Educators in Medical Care

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Certain characteristics of the medical care system profoundly affect criteria and prospects for credentialing health educators in this practice setting. To stimulate identification and discussion of the issues, this brief paper points out some salient features of medical care as it exists in the U.S. today and raises some related concerns for standards of professional preparation and practice.

1. The public, health care providers, and policy-makers are attributing increased importance to health education in medical care, but the reasons for this heightened interest differ. Consumers disenchanted with the existing system and newly conscious of their rights want straightforward information on their health status, their needs for medical care, the competencies of providers, and the risks and benefits of alternative courses of treatment. Providers are concerned about improving patient compliance with medical advice, as well as with conserving physician time. Institutions look to education as a new source of revenue in times of economic stringency, and also as a marketing device to assure high hospital bed occupancy rates. Legislators and insurance companies expect health education to help control health care costs. The anticipated outcomes of education in medical care therefore vary, and are not always compatible with goals of informed decision-making. Is credentialing to be concerned only with the effective performance of educational functions regardless of goals, or should the ends as well as the means of practice be considered? Whom shall education serve? What groups should it empower?

2. Medical care is organized to expedite the delivery of medical care, not education. Decision-making hierarchies, formal and informal lines of communication, leadership patterns, power relationships, work

priorities, buildings and architecture, and even the language of medical care are structured to facilitate the hands-on care of patients. The planning, organization, and delivery of effective educational programs therefore must take place in an environment laden with social and structural obstacles. Not the least of these is the problem of reaching agreement on the nature of educational content, for control of information is a major mechanism of social control in medical care institutions. To operate effectively in this milieu, the health educator must be able to assess the dynamics of complex and interacting systems, to gain acceptance and credibility in an alien culture, and to effect planned change, not only in individuals, but in organizations. Survival skills are prerequisite. While the generic role delineated for the health educator may be necessary, it is unlikely to be sufficient. What, then, is the appropriate preparation and entry level for health educators working in medical care?

3. Physicians, nurses, and other health professionals regard health education as their responsibility. Although this has been traditionally so, new emphasis on the importance of health education has led to new interest--and territoriality--on the part of various health professionals. Many physicians resist the provision of patient education by others on the grounds that only the doctor has full knowledge of the patient's case, that the doctor is held legally responsible for patient care, and that the involvement of others in education interferes with the doctor-patient relationship. Nurses, exerting their independence and expanding their own professional identity, claim that education is an integral part of quality nursing care. Dietitians, social workers, pharmacists, the clergy, and a host of other professionals similarly are specifying their particular educational roles and responsibilities in medical care, some with a good deal of sophistication. Related training programs and research projects, although variable in quality, not only visibly stake out turf but often contribute to strengthening educational practice. On what basis, then, can health educators claim that their skills and knowledge are unique? Rather than try to establish professional boundaries, shouldn't our stance foster interdisciplinary

collaboration and educational resource development? Isn't this politically the only viable alternative? And isn't such sharing the essence of education?

4. Massive social forces are converging to create enormous pressures for change in medical care. The decrease in infectious diseases and the increased prevalence of the chronic diseases, concomitant with changes in the age structure of the population, have altered needs and demands for medical care, as well as patterns of health care delivery. The technological explosion has expanded greatly the repertoire of medical interventions, leading to increased medical specialization, the mushrooming development of new health professionals, the uncontrolled growth of the health care industry, maldistribution of resources, and escalating health care costs. Business and industry, pressured by worker illness, rising insurance costs, and reduced profit margins, are organizing their own health programs and renegotiating relationships with medical care institutions. At the same time, the women's movement and increased consumer attention to equal access, quality care, and informed consent have thrust decisions about medical care into the political arena, as well as the legal/judicial system. Society's efforts to cope with these problems have resulted in a labyrinth of regulations, new forms of health care organization, and new financing mechanisms. None of these "solutions" has yet achieved notable success, but all have contributed to the intensity and turmoil of change.

Hospitals and other medical care facilities therefore are caught in an enormous economic and political struggle involving many sectors of society. The stakes are high and vested interests are strong. One result of particular relevance to the development and implementation of standards for health education specialists has been the declaration of a moratorium on the licensing of nontraditional health workers. Is credentialing of health educators in medical care feasible in this maelstrom of events? How can meaningful standards of professional practice be set when there is so much instability in the system? Will medical care institutions tolerate only the performance of those educational functions that preserve the status quo? And is "playing it safe" to protect

the availability of jobs in medical care more important to health educators than the challenge of applying education to help resolve fundamental difficulties in the relationship between people and their health care institutions?

The complexity and magnitude of these issues indicate that achieving quality health education practice in medical care settings is a formidable task. Standards unquestionably are needed when the well-being of patients--and sometimes even their lives--depend on educational effectiveness. Also necessitating the development of meaningful guides to professional practice are expectations held by various powerful segments of our society about the contributions health education can make toward alleviating major medical care problems and the desire of health education specialists to perform constructively in this important arena of change.

While the need for standards therefore is not disputed, questions arise about how standards best can be set. The delineation of a generic health education role accompanied by related curriculum development and credentialing efforts represents one approach. Nevertheless, before investing substantial professional resources in this endeavor, potential payoffs must be carefully weighed against those likely to be attained through alternative uses of limited time and energy.

In our considered view, professional standards must be derived from a thorough analysis of the educational needs of particular population groups combined with an assessment of the opportunities, constraints, and resources that shape health education practice in particular institutional contexts. The identification of functions common to all health educators working in all practice settings draws attention away from critical differences that cannot be ignored in determining the nature of quality health education performance. Diluted generalizations provide little guidance either for practitioners or for institutions preparing health educators to work in the real world of people, problems, and organizations.

Approaching standard-setting through the definition of a generic health educator role also neglects realities of how standards become accepted and implemented. A close appraisal of current accrediting mechanisms and those likely to be operative during the next decade offers little hope that standards for the professional preparation of health educators can be applied effectively through this channel. Prospects for enforcing health education standards in the field are likewise extremely dim except as institutions and agencies voluntarily set criteria for hiring and job performance.

Health education theory and practical experience provide ample evidence that those who are expected to act voluntarily must be involved both in analyzing the problem and in developing an acceptable solution. Nevertheless, by drawing together health educators from many streams of practice to define their common functions, the Role Delineation Project excludes organizational decision-makers and special interest groups from active participation in the standard-setting process. Both for this reason and because a generic role cannot reflect adaptation to the unique concerns and characteristics of specialized realms of practice, the standards developed by health educators acting ecumenically with each other, but in isolation from other sectors of society, are likely to find minimal acceptance and probably considerable resistance among those with standard-setting powers in medical care.

The Role Delineation Project rests upon the premise that the definition of common health education functions and a generic role will unify health educators working in schools with those working in other institutions and communities. Such unification, in turn, is considered important in increasing societal support for professional health education preparation and practice. In response to this argument, we suggest, first, that societal support for any profession is merited and won only to the extent that this profession demonstrates particular abilities to impact on significant societal problems. Second, while we agree that professional unification is important in obtaining greater societal support, we point out that role delineation is only one

approach through which unification can be accomplished. As indicated previously, the definition of a generic role directs attention away from the critical health problems that should be the focus of professional health education practice, because these problems differ in different practice settings. Moreover, role delineation leads health educators to devote their time and energy to internal professional concerns at the expense of their active involvement on the front lines of attack against society's ills. Neither society's problems nor organized efforts to control them will wait unchanged while health educators encapsulate themselves in a professional vacuum to define their common role.

These considerations lead us to conclude that our professional identity will best be forged and our professional practice advanced as we consolidate our resources to confront the major health problems plaguing society today and emerging to plague us tomorrow. Our roles will necessarily vary as we work from different bases to address different health needs in different population groups. Our unity therefore will not be found in role performance, but rather in our combined efforts to address massive social tasks, our philosophy, our values, and our commitment to achieving a healthier society through education. Medical care is one crucible in which societal change is occurring and in which we must get on with the job as part of a larger systems approach.

Credentialing: Implications for (School) Health Education

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My assignment is to present to you the concerns about credentialing from the perspective of school health educators. For me, the hardest part of this task is to view health education as separate programs for different settings. I think of myself as a health educator--not a school, community, or medical care educator. Nonetheless, for the purposes of this panel, I have tried to limit my remarks to the special concerns of health educators who work in school settings.

It may well be that credentialing raises fewer concerns for the professional preparation of health educators in schools than it does for the professional preparation of health educators for work in other community settings, including medical care. This is because there is a history of credentialing for elementary and secondary school teachers, who constitute the great majority of those intending to practice health education in a school setting. The traditional credentialing includes institutional accreditation, curriculum approval, program registration, and the licensing and certification of graduates.

For example, the institution providing the professional preparation may be accredited by the National Council for the Accreditation of Teacher Education (NCATE).

The Health Education curriculum itself may be reviewed and approved by a State education authority. Traditionally, programs must be registered with the State education authority.

The successful graduates of such programs are eligible for licensing as teachers and also for certification as health education specialists, in states where such certification exists.

Though there may be weaknesses in the processes for determining the extent to which standards have been met, there is no lack of credentialing. There are nonetheless some real concerns relating to credentialing for health education programs leading to professional practice in school settings. I will address myself to three of these.

1. The lack of uniform national credentialing for health education.

The type of accreditation provided by NCATE is institutional in nature. A participating university or college is reviewed and rated in terms of schoolwide standards and may receive institutional accreditation. However, there are no standards specific to health education. Professional preparation programs in health education may receive a cursory or a careful review by site visitors who may have minimal or extensive knowledge of the field. Accreditation by NCATE is therefore not evidence of an institution's meeting of standards that are specific to the field of health education. (This situation is similar to the schoolwide, rather than programmatic, reviews of schools of public health by the Council on Education for Public Health.)

There is a lack of uniformity in the way school health educators are prepared across the country. Universities develop their own programs, which differ considerably. This same lack of uniformity applies to the standards and approval procedures applied by State education authorities, who have the legal responsibility for education. Because the authority lies with State and not with Federal Government, there could be 50 different curricula for preparing school personnel for health education functions.

In fact, the wide variations of State requirements for professional programs have resulted in differences in range and depth of subjects studied, duration of the curriculum, nature and amount of field work, minimum competency, expectations, and the qualifications of faculty leadership. No only do the existing standards vary, but so does the monitoring process. Standards on paper are not necessarily those in

practice. Professional preparation of school health educators in the United States is not one, but many things. Though variation is not in itself a weakness, there is concern that health education leaders have the skills and knowledge to make maximum contribution to the education of the ultimate consumers: children and youth in schools and their families. At least minimum standards should exist in all states. And health educators should be able to have credentials that will enable them to practice in any of the states of the nation, a situation that does not exist at present.

2. The lack of uniformity in the basic professional preparation of entrylevel health educators, regardless of the settings in which they are preparing to work.

At present there is a proliferation of institutions of higher education providing entry-level (whatever that is) preparation of health educators. Currently, approximately 108 institutions offer baccalaureate preparation, and approximately 80 offer Master's programs. Traditionally, students preparing for teaching or other educational work in school settings have studied in schools or colleges of education.

Those preparing for health education in non-school settings have studied in schools of public health. Often there is little communication or collaboration among these units, even where they exist on the same campus. And, although there has been a growing agreement within the profession that there is a common core of knowledge and skills needed by any kind of health educator, the preparation continues to be separated, for the most part. This has created some obvious problems:

- A lack of uniform standards, uniformly applied;
- A lack of appreciation of the health education profession as a single profession, not several;
- The limitation of communication and collaboration among the different health education specialists during their training for a field that requires cooperative efforts;
- The misunderstanding on the part of the public, including employers, of what health educators are prepared to do.

The often competing professional preparation programs, professional health education organizations, and even government departments and bureaus have contributed to the lack of professional growth of the field. There is no single voice for the field, and there needs to be.

Because schools are part of the community, and school personnel usually view themselves as school/community professionals, it has been a natural occurrence for health educators prepared primarily for teaching positions to move into community (non-school-centered) health education jobs, either out of choice or out of a lack of teaching opportunities. Since there is no license or other special credential needed, this has been an easy transition. On the other hand, the movement by community health educators into school positions, especially teaching, is not as easy because there are licensing and sometimes certification requirements.

3. The need for one basic curriculum to meet the entry-level credentials for school/community health educators.

For the professional preparation faculty, the challenge is to provide an entry-level curriculum that prepares students for more than one setting. A few such curricula exist. Also, some institutions encourage the individual tailoring of professional preparation programs to permit students simultaneously to earn the community public health education credential and to fulfill qualifications for teaching health education. As the need for trained health educators in medical care settings expands and the standards for such specialization are defined and applied, there will be further concerns about proliferation of training.

Concluding comments:

In a very practical sense, my everyday on-the-job concerns about professional preparation of school health educators and community health educators, as well as several kinds of specialist (sex educators,

alcohol specialists, environmentalists), force me to deal with such issues as:

a. Explaining to administrators what health education is (and is not) and why they should support morally and financially the several curricula, the required State approvals, and several accreditation processes.

b. Dealing with several different accreditation groups; providing the faculty time for self-study, site visits, and follow-up, the extra secretarial time and patience; budgeting for ever-increasing annual fees and the special costs of the review process; and when it is all over, wondering whether accreditation is worth the effort.

c. Advising health education students and potential students about their choice of university, their choice of specialization, and their probability of employment in the area or areas they choose. Explaining accreditation and certification and their relationship to employment.

d. Teaching about the profession to students in training; interpreting the credentialing situation; and encouraging acceptance of the need for uniform standards, uniformly applied by qualified professionals. Encouraging a broad view of the field.

e. Determining in which professional health education organization to be most active during a given year; paying the dues of too many; and wishing our profession had a single "voice."

f. Intepreting the field to outsiders. Even health-related professionals do not understand what it is and what health educators do.

g. Searching, as an individual professional and as a member of a health education faculty, for a solution to the problem of defining across-the-board standards that will make it possible for health educators to be able to fulfill the potential of helping people at any age--in any setting--live healthier lives.

Will credentialing make a difference? Will it really have a positive effect on the achievement of our nation's health goals? Will it protect the public? That, of course, must be the ultimate concern.

Credentialing: Implications for Institutions and Programs

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Background and Definitions

Most people agree that personnel credentialing has a basic purpose of consumer protection. By licensing, certifying, or registering personnel, the public can recognize practitioners who have met certain educational and professional standards and are presumed to be competent to deliver services. According to the National Commission for Health Certifying Agencies (NCHCA), more than 100 health fields are regulated or seeking regulation by some sort of credentialing mechanism.(1)

If we are to consider credentialing and its impact on educational institutions and programs, we must consider it in relation to a number of quality control mechanisms that, together, make a significant impact. Four basic categories of activity designed to insure quality of educational programs and professional practice are:

- Accreditation of educational programs
- Credentialing of personnel--through licensure, certification, or registration
- Peer review of performance
- Continuing education.

1. First, let us look at accreditation. Accreditation is "the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined standards....Accreditation is usually given by a private organization created for the purpose of assuring the public of the quality of the accredited (such as the Joint Commission on Accreditation of Hospitals)...."(2)

The impact of accreditation on educational programs is quite direct. Accreditation provides peer review of and influence on what should be in the program--its curriculum content and sequence, qualification of faculty, availability of facilities and resources, educational support services, and the like. For each program "essentials" (or minimum standards) are developed; faculty assess their own programs in light of the essentials, using a self-study process; peers from similar programs and institutions conduct site visits and evaluations, based on standards contained in the essentials. Graduation from an accredited educational program is normally a prerequisite for eligibility to take a credentialing exam and thereby enter into practice.

2. Credentialing of personnel is "the recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership or the award of a degree in the field....Credentialing also determines the quality of personnel by providing standards for evaluating competence, and defining the scope and functions in how personnel may be used."(3)

a. Licensure is "permission granted to an individual or organization by competent authority, usually public, to engage in the practice, occupation or activity otherwise unlawful...."(4) Licensing is the most restrictive form of occupational regulation because it prohibits anyone from engaging in activities covered by the scope of practice without permission from a government agency. There are a number of health occupations and professions covered by licensing laws in one or more states--including audiologists/speech pathologists, chiropractors, clinical laboratory personnel, dental hygienists, dentists, dietitians, emergency medical technicians, medical technologists, licensed practical nurses, registered professional nurses, nursing home administrators, occupational therapists, optometrists, pharmacists, physical therapists, physicians, psychologists, radiologic technologists, respiratory therapists, sanitarians, social workers, veterinarians, and others.

b. Certification is "the process by which a governmental or nongovernmental agency or association evaluates and recognizes an individual, institution, or educational program as meeting predetermined standards. Essentially it is synonymous with accreditation, except that certification is usually applied to individuals and accreditation to institutions. Certification programs are generally nongovernmental and do not exclude the uncertified from practice, as do licensure programs...."(5) Shimberg, in a recent paper on "National Developments in Health Occupations Credentialing," explains both governmental and voluntary certification processes. He points out, "For example, in many states anyone may practice accounting, but only those who have met State atandards may call themselves 'Certified Public Accountants.' Unlike licensing, the law does not prohibit non-certified individuals from engaging in apecified activities; however, it does prohibit them from using a given title or from holding themselves out to the public as being 'certified.'"(6)

One interpretation of the difference between licensure and certification is that licensing is concerned primarily with safe/unsafe practices, whereas certification deals with differentiating the excellent from the good. In voluntary, i.e., nongovernmental, certification, many professional and trade groups grant recognition to individuals who have attained certain entry levels or are qualified in special areas of practice or have superior competence in given occupations. Shimberg points out that while all physicians must be licensed by the State before they can practice, those who meet standards set by nongovernmental certification agencies may be recognized for their competence in various fields of specialization. Hence, various specialties of medicine have their specialty boards, which voluntarily certify physicians who pass examinations and meet other requirements. At present there are 23 medical apecialty boards, none of which are based on any law. They represent a voluntary effort on the part of occupational grpups to grant recognition to those who have achieved a required degree of knowledge and skill in a given field.(7)

c. The third form of credentialing is registration. It is "the process by which qualified individuals are listed on an official roster maintained by a governmental or nongovernmental agency. Standards for registration may include such things as successful completion of a written examination given by the registry, membership in the professional association maintaining the registry, and education and experience such as graduation from an approved program or equivalent experience...."(8) Registration is used in situations where the threat to public health safety or welfare is minimal. It should be noted that although some disciplines are called "registered," as in Registered Nurse, they are, in fact, licensed.

Any group can set up a certification process and set standards in the non-governmental sector. In fact, there are so many certifying bodies in the health care occupations and professions that recently (1976) the National Commission for Health Certifying Agencies (NCHCA) was organized to develop standards for recognition of health certifying agencies--in other words, to "accredit" the certifying agencies. According to the NCHCA, there are more than 100 health certifying agencies. Currently, approximately 45 different occupations in the health field are regulated, 14 of them in all states.(9)

3. Peer review is a third quality assurance mechanism, primarily utilized in the medical sector at the present time. Public Law 92-603 authorized development of Professional Standards Review Organizations (PSRO) primarily for reviewing utilization of certain government medical care programs such as Medicare, Medicaid, and child health services. At present, peer review of professional performance is not widely utilized by allied health disciplines but is being studied for applicability as a quality control mechanism for future utilization.

4. The fourth quality assurance mechanism is continuing education. Continuing education is often tied in with continued certification to assure additional study toward updating competence and proficiency. Many of our professional disciplines are beginning to mandate continuing education for continued recognition and recertification.

Several groups, such as medical record administrators and dietitians, mandate specific clock-hour requirements of continuing education over a period of time. Failure to maintain these requirements results in loss of certification.

Unfortunately, the groups mandating continuing education often cannot specify continuing education for what. Ideally, one should know the level of knowledge, skills, and behaviors demanded by advancing technologies and practice and should base continuing education (or any other learning mechanism) on making up the difference between the "is" and the "ought." Until we tie continuing education with specific knowledge and skills required of the profession, we are likely to be spinning our wheels in that continuing education offerings may not be related to specific advanced knowledge, skills, and competencies required. What good, for example, is a continuing education course in Financial Management for the physician? It may be good for him or her as an individual but does not extend his or her skills as a practitioner.

But the fact that our state of the art in coninuing education is imperfect should not negate our recognition of continuing education as an attempt at quality control and continued competence.

Processes and Issues

Let us go back and examine the process of developing credentialing standards and procedures. First, we must start with a baseline of knowledge, skills, and behaviors or competencies necessary in order to practice the discipline (i.e., minimum standards for getting the job done effectively). Second, these standards must be translated into reliable and valid tests that can evaluate the extent to which the individual measures up to these standards. Third, a system should be developed of recognition of the individual who measures up to the standards of excellence of the discipline.

There are several issues in credentialing. One of the weaknesses of voluntary certification is the absence of standards. Any group

wishing to establish its own certifying agency is free to do so. Often in the past, as a group moved toward professionalism, it would organize a national association, which would then set up an accreditation organization for program accreditation and a credentialing organization for individual recognition. Usually these organizations would be part of, or closely related to, the professional association, a situation leading to claims of conflict of interest. For example, until a few years ago the American Speech, Language, and Hearing Association mandated membership in their professional organization as a precondition for eligibility to sit for the certifying exam. This was ultimately challenged in courts and the court ruled against the Association, so that membership in the Association is no longer related to the certification process.

Recently the Federal Trade Commission (FTC) and others have been accusing some of the health professions of being so self-interested that they are fostering restraint of trade. We realize the same mechanisms that are designed to assure quality of care can also be used to control numbers of people in the profession, restrict competition, and have certain economic spin-offs. Recently FTC challenged the dental profession about whether or not dentists are restricting trade in controlling the practice of dental hygienists through dental practice acts in each state. This issue, therefore, involves the legitimacy and the public interest of the credentialing agency. Is it in the public interest to have a special interest group be its own judge and jury? Generally the professions say "yes" because they believe that nobody else is capable of judging their competence. Others, however, are focusing on alleged conflict of interest.

Another issue relates to prerequisites for taking credentialing examinations. Eligibility to take credentialing examinations in most health professions normally excludes those who did not graduate from programs accredited by the recognized national accrediting agency. This raises the issue about learning that takes place in nontraditional settings--on the job, self-learning, military programs that do not meet

civilian accreditation standards, and the like. In addition, there are conflicts among organizations about claims to accredit programs, as has been exhibited by the conflict between the American Physical Therapy Association and the Committee on Allied Health Evaluation and Accreditation (CAHEA). Both organizations seek to be the recognized national accrediting body. Consequently, some of us have physical therapy educational programs accredited by both groups, pending resolution of the conflict.

Implications for Programs

What does all this have to do with implications of credentialing for institutions and programs? Credentialing has a direct impact on practitioners and the occupations or professions in that it influences their ability to practice as individuals. Educational institutions judge programs to a certain extent on how well their graduates perform on the credentialing examinations. We can compare our performance with other, similar schools and programs in terms of the percentage of candidates passing on the first attempt or on examination scores. Usually, if a graduate fails, we can identify areas of weakness and examine our curricula and instruction in those areas. Indeed, one of our own college objectives is that all our graduates pass the particular credentialing exams on the first attempt. A second objective is that our graduates will exceed national and regional averages on credentialing examinations.

Feedback from credentialing examination results represents one kind of external evaluation. It lets us know how our students perform as compared with students from other programs. Whereas accreditation provides prospective evaluation focusing on process, credentialing examination results provide retrospective feedback on the product.

My major observation, however, is that one must consider accreditation, certification, and other quality assurance mechanisms together. They influence one another; hence, they influence educational programs collectively. I would like to mention, however, that accrediting and

credentialing standards represent minimum acceptable standards; educational programs strive to achieve much more than minimums.

Health sciences may be unique in the rapidity of technical change and its impact on manpower requirements and needs. For each new technique comes a new specialty--for example, with rapid developments in ultrasound, we now have a relatively new discipline called "diagnostic medical sonography." The new group is working with the Committee on Allied Health Evaluation and Accreditation (CAHEA) to develop essentials for accrediting programs. With that as a newly recognized discipline and with "essentials" for accreditation, credentialing procedures will follow for individual recognition. All these events will influence the eventual curriculum design of programs to prepare the sonographers.

Implications for Health Education

How does health education fit into this kind of schema? Assuming you want to recognize those health educators who are appropriately prepared and meet certain standards of excellence, then you may wish to develop a credentialing process. With the current state of the art, I would argue against licensure as a form of credentialing for health educators. I would recommend that you avoid the restrictions of licensure in that licensure would exclude those who are not licensed from practicing the discipline--and that would be quite impossible if we tried to exclude the many people who are working in some aspect of health education. I would argue for a voluntary system of certification for health educators--recognizing those who meet certain defined educational standards, knowledge, skills, and competencies--but not precluding others from practicing (see the analogy to Certified Public Accountants, mentioned previously). Such a system would guide potential employers to choose preferentially one who is recognized by the professional "seal of approval."

The National Center for Health Education, through its Role Delineation Project, has made a good start by identifying the skills, knowledges, and behaviors expected of a health educator. This could be

the framework for setting the standards that stress excellence and developing the measures to evaluate those wishing to demonstrate their excellence via the certification process.

Failure to meet standards would not necessarily deprive individuals of the opportunity to work, but it might prevent such individuals from getting the best jobs. This, then, would provide an incentive for practitioners to seek additional education, training, or experience in order to meet the group's certification requirements. It also would help employers to evaluate an applicant's credentials. There are possible future implications toward arguing for third-party payment for services rendered--assuring the third-party payer that a qualified individual (i.e., certified) rendered the services.

As pointed out in the National Commission for Health Certifying Agency report, the challenge will be to design appropriate test instrumenta that effectively measure skills, knowledge, and professional attributes deemed essential for competent practice. In some credentialing exams, individuals have challenged the validity of tests on the basis of a lack of job relatedness.(10) There is another problem in defining the domains of the subject to be assessed in implementing appropriate test mechanisms.

Usually, credentialing exams are written (paper and pencil) to reflect measures or levels of academic performance, and usually, these exams are process-oriented rather than outcome-oriented and normally do not measure such attributes as interpersonal effectiveness or motivation.

In some cases, practical examinations are given; an example is dental hygiene and dentistry, where the graduates perform clinical procedures and are evaluated by experts. The problem with practical examinations ie that of cost and difficulty in administering the examinations.

Needed also are equivalency and proficiency examinations that measure the ability to do the job (proficiency) and measure learning

that has emanated from nonformal educational programs (equivalency). An example of the need for this is placing graduates of military educational programs into civilian programs or testing them for certification in the civilian sector.

There are two kinds of system for evaluating examination results: norm-referenced and criterion-referenced examinations. The norm-referenced examinations identify the relative standing of all people taking the examination--in other words, grading is on the curve, with the pass/fail threshold usually being one standard deviation below the mean. In norm-referenced examinations, you are assuring that there will be failures--i.e., below one standard deviation.

Many of the health fields are now converting to criterion-referenced examinations, which grade according to a certain score. These examinations require well-defined domains and criteria for pass or fail. First, one must define the abilities, knowledge, skills, and other attributes; and performance standards must be set. Pass/fail scores must be set. Some disciplines may set their scores unrealistically high or low--it is possible for all to pass or none at all. It is helpful to engage the assistance of psychometrists, who are skilled at test construction and evaluation.

Criterion-referenced examinations can be developed by a panel of experts to outline essential competencies in the particular discipline, or one can start from a basis of task analysis--making observations regarding actual job performance in order to identify the essential elements of the discipline.

Another thing to consider is whether the standard for pass/fail should be based on the entire test or whether the test should be divided and graded in subparts, each with a pass/fail cutoff point. For example, our physical therapy examinations have three parts, each with a pass/fail mark; hence, a graduate may fail one of the three parts but will not have to take the entire examination over. This system also

provides feedback for the educational program in terms of areas of strength and weakness in the curriculum.

Scope of Practice/Role Delineations

One of the major purposes and effects of credentialing, as pointed out in the NCHCA report, is to delineate the scope of practice of each regulated profession.(11) Typically, this occurs through licensing statutes and voluntary certification procedures. The delineation of scopes of practice is becoming increasingly important (role delineations) with the proliferation of professions and specialization within professions. As changes in health care delivery systems mandate changes in scope of practice, some statutory definitions become outdated or are inflexible or oppressive. Very often these definitions and scopes of practice overlap one another. For example, the NCHCA report analyzes the lack of clarity of roles among psychiatry, psychology, and social work scopes of practice.(12) This may complicate credentialing processes if several groups of practitioners lay claim to overlapping roles or scopes of practice.

Summary

Four mechanisms can be identified that are designed for assuring quality and competence of personnel, hence, consumer protection. They are: accreditation of educational programs, credentialing personnel, peer review of performance, and programs of continuing education.

I would like to recommend that health educators start from the results of your Role Delineation Project, in which the scope of practice is quite well defined. Among credentialing mechanisms, I would recommend that you opt for a voluntary certification process that will recognize those with the educational backgrounds, knowledge, skills, and behaviors required for ethical health education practice. Next, utilize experienced psychometricians for assistance in the construction and validation of appropriate credentialing examinations. Organize a group to implement the certification process, and link up with the National Commission for Health Certifying Agencies for assistance in developing guidelines and procedures.

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Options and Opportunities: Recommendations for Future Action

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Introduction

The original planning for this event indicated that at this point in the conference, we would need a transition--something that would move us from deliberation to action; something that would move us from problems to developing specific steps to solve problems; something that would help us move from possibly vague anxieties about credentialing to perhaps more specific anxieties that can be addressed and dealt with; something that would open up the future to opportunities rather than narrow it down to limited alternatives; something that would move those of us who might be reluctant to take the next steps so that we will be willing to venture into the uncharted future and to become somewhat more crusaders for credentialing; something that would light us on fire, to help us "get our act together" as faculty members in institutions that have as their goal the preparation of the finest possible health educators we can prepare. This transition will hopefully move us in some of these directions, although it is possible I have "canceled myself out" by trying achieve too many objectives in such a short time. It appeared to us in the planning stages that the task for this session would be to both "calm the troops" and "incite them to riot," depending on how the conference was progressing; to both encourage specificity if we were getting too vague and encourage generality if we were getting down too far to the "nitty gritty"; and to encourage visiog if we were looking only toward tomorrow, but to encourage short-term concerns if we were postponing action by looking too far into the future.

The title of this part of the conference program, "Options and Opportunities: Recommendations for Future Action," is meant to imply a number of things: (1) First, it is meant to suggest that we do indeed

have options for the future--we have options to reject or to support the Role Delineation Project now or in its later stages; we have options as individual faculty members, as faculty members acting jointly with our academic colleagues, and as individuals who are members also of professional organizations and other groups. (2) Second, the title is meant to imply that there are indeed opportunities--opportunities to improve the status of the profession, opportunities for our graduates to achieve national health goals, opportunities, if you will, to continue our "becoming," as Gordon Allport would have called it--"becoming" as a profession. These opportunities may have always been around, but now we have the stimulation of the Role Delineation Project to help us. (3) Third, the title is meant to imply that recommendations are sought, sought by the Task Force guiding the project and sought by the agencies that have assisted in its implementation. But beyond these concerned groups, in truth, we, as representatives of academic programs, may also be seeking recommendations. Because we have not had an effective way of dealing collectively with the problems of credentialing as educational institutions, we must sometimes deal with intermediaries and use less direct ways of planning how to proceed as educational institutions. (4) Last, the title is meant to suggest the need for future-oriented recommendations. As in all ventures of this kind, it is probable that each of us would have had suggestions for alternative ways of listing responsibilities, functions, skills, and knowledge. Some of us may have had input into the project; others may not. In any case, we cannot go back. It is time to go forward; and we are looking forward to hearing future-oriented recommendations in the next group discussions, based on your view of the overall project and the steps planned.

As we approach the task of making recommendations, it seemed to the planning committee that we needed a focal point for the recommendations. Rather than make recommendations to many different individuals, groups, or organizations, we thought it more effective to deal directly with the group most involved to date. We are requesting, therefore, that the recommendations be formulated in such a way that they can be actions the National Task Force can take. This procedure is not designed to prevent you from making recommendations to other groups, for it is possible to

suggest that the National Task Force either initiate action or implement action. But by having the members of this group as the focal point, we are assured that there is a responsible group present that can, at a minimum, take the first steps to get things moving, even if another group or groups are to be involved subsequently.

As we think about recommendations to the National Task Force, it is possible to see the Task Force as an action group (taking action on the recommendations that may fit as a part of their current charge); as a stimulator (encouraging other groups with charges or available opportunities that would indicate they could move more appropriately or effectively on given issues); or as a clearinghouse (moving communications as needed among the different groups).

Contextual Framework for Recommendations

Our approach to making recommendations will be dependent upon so many things--our agreement or disagreement with what has been done; our understanding of what lies ahead; our views of the so-called generic health educator; and our views of a host of other things that are included on the flow chart describing the several major steps involved in the Role Delineation Project.

Further, our discussions and recommendations are not taking place in a vacuum; and all of you can think of some of the forces at work, both positive and negative.

I would like to suggest, however, a few contextual issues that have particular relevance to those of us from education institutions. Let me just mention a few.

The Time Line

For many of us, there is a need to place the credentialing process on a flow chart and on a realistic time line in order to see what "crunch" or "crunches" may be ahead in terms of allocating personal, organizational, and financial resources. It would not be at all unrealistic, in my view, to see a decade or more required from beginning to

end of the two major lines of development in Alan Henderson's flow chart, ending in the final "arrival" of the first credentialed entry-level health educators.

Some of us may be looking forward to retirement, so we do not have to worry. Others of us may decide to take early retirement to avoid facing the problems. Still others of us are going to have to cope with the problems, and I hope there are going to be enough young faculty in strong programs to carry the academic part of this projected load.

If one accepts the frequently heard proposition that the half-life of a professional curriculum is five years, we can see that during the development of this project, if this all happens within ten years, we will have only one quarter of our current knowledge base intact by the end. This fact alone would require, therefore, an enormous amount of networking and communication among the parties involved, particularly the educational institutions, to keep us all moving somewhat together and to keep us all current.

"Freezing" or "Unfreezing"

Another sort of situation that may be confronting some of us is a concern that evolves not only from the curriculum half-life problem but also from the problem of changing roles and practices. The statement that has evolved from the Role Delineation Project to date probably would not have been the same if it had been developed ten years ago. Likely it would not turn out to be the same if the statement were to be completed ten years hence. Therefore, a question arises about building changes into the plan, thereby assuring the profession that it still is open-ended, growing, expanding, and being increasingly creative. In this light, therefore, some of us may be wondering whether we are going into a stage that Lewin called "freezing" or whether we are truly moving into an "unfreezing" stage. Whether you believe we are moving into one or the other as a consequence of the work on credentialing will partially determine how you approach the recommendations for action.

Perhaps some may see us "freezing" the profession--by seemingly closing off options for expansion, broadening, or altering roles and responsibilities and by making what seems to be a hard and fast statement at this time. On the other hand, perhaps some will see us, "unfreezing," by breaking down specialities, by developing a generic view of the profession, and by continuing the creative interorganizational dialogue that was begun in earnest with the Coalition of National Health Education Organizations. Perhaps we are "freezing" by putting in place all the structural elements required for professional development. On the other hand, perhaps we are "unfreezing" by getting some of the groups together--like the academic programs--and helping them increase their intercommunication and collaboration. Maybe we are doing both simultaneously. You will have to decide from your own unique view whether you see us moving one way or the other, the values that are enhanced or lost as a result, and how these factors will affect the future.

"Coming of Age" and Accountability

I am not sure that if each of us could have dreamed his or her wildest dream for the profession, we would have picked the goal of credentialed entry-level health educators as an end point. Rather, I suspect we would have placed emphasis on something like a health educator in every health agency--like a chicken in every pot--as a goal. Or perhaps we would have said we do not care about all the professional paraphernalia; rather, we are concerned about what happens to people in the community or kids in the schools. Are they any better off because we as a profession are there? Or is our society any better because we are there? Just a little better? Some of us, then, may perceive the organizational steps in development of the profession as irrelevant, or at best, a necessary evil.

In truth, I think most of us would wish for an idyllic world of only moderate accountability. Unfortunately, that kind of world does not exist and will not exist in the future.

Whether we like it or not, we must respond to outside societal pressures, and accountability, quality control, and self-regulation are part of the demands placed on us as the price of "coming of age" as a profession.

Appropriate Academic Concerns

Another contextual issue I would like to raise is the relationship of academicians to the credentialing process. In a major document prepared for the National Forum on Accreditation of Allied Health Education about a year ago, John Schermerhorn found most educators feel strongly that the educational institution is not the proper arena for the upgrading of professional practice. Rather, it is the responsibility of the professional society and its membership. The educational institution, then, must be responsive, within its capabilities, to the needs of the professionals, the employers, and the public; and it must not be forced, by any means, to take positions in support of any one group at the expense of others. I found this a perplexing statement, since those of us who teach practitioners have ourselves been intimately linked with practice at one time or another in our lives, and most of us belong to the same professional organizations as practitioners do--indeed, we are often the same group. What makes us different as academicians in response to issues of credentialing?

Should we respond at all to role delineation, role specification, and all the rest, or should we simply wait until the profession tells us what it intends to do, and then respond within the limits of our academic world? Our being here would suggest we see a more active role for ourselves. Up to this point, however, we have not had an organized way to respond as academic institutions. Some of us have participated through representation on the various committees and task forces in the whole development of the project, but as someone in the Towson State meeting said in December last year, "There is a definite overrepresentation of academicians in the Role Delineation Project." Is it time to rethink this issue? If we should be responsive to the needs of professionals, employers, and the public without supporting any group, and yet we are so identified with professionals because we are they, and they

are we, how can we be responsible to the needs of employers and the public as effectively? As most of us know, credentialing has been criticized by many as being protective of the profession instead of the public. Will we contribute to that professional protection at the expense of our other responsibilities? Some hard thinking on the responsibilities of academic institutions and their faculties is needed on this point.

Some Emerging Process Issues

It has seemed to me, as I listened in our own group discussion, and as I had a chance to talk with participants and faculty, that a number of what I have called "process issues" relating to our consideration of recommendations have arisen. Let me list just a few--clarity, anxiety, diversity, and solidarity--and deal with each briefly.

Clarity - clarity of where we want to go. We were challenged, I believe, by Salman when he asked us, "Where is it you really want to go?" This question asks us, then, to decide where we want to be as a profession, say, in 1990. How healthy (as a profession) do we want to be in 1990, if I can use an analogy from the document Healthy People? Do we want more programs to prepare health educators? Do we want better programs preparing health educators? Do we want more capable graduates? More political clout? More access to resources? Do we want to make a contribution to achieving the health Objectives for the Nation? Or do we want to achieve greater coherence in our joint missions? We have been encouraged, also by Salman, to "avoid mixing the ideal with the actual." How then do we handle short-term and long-term goals--the here-today reality with the tomorrow ideal? Helen Cleary mentioned how important it is for us to define action steps for the here and now--like, "What do we do when we go back home to help in the Role Delineation Project or Role Verification stage of that project?" We all know, however, that what we do next must also be seen within the framework of where we want to be "in the long haul."

Anxiety - I am aware, as most of you are as well, that while we have been working together, a number of people have admitted that they

were more than a little concerned about this entire development. Some participants may have been threatened by the credentialing process, and some have openly admitted it. Someone said to me, "I am frustrated by this meeting, but I am feeling better now because I can now at least understand the jargon about credentialing." Someone else said, "I do not know yet what I think in order to make recommendations, because I am still confused and do not have enough data about what the future holds for me and my institution if credentialing emerges as an important force. The full consequences or the relative costs of taking one or another step next are not clear, and I am anxious about committing myself to a specific recommendation right now."

I also sensed that some participants may be wondering whether their programs and/or their specific jobs may be in jeopardy. Perhaps they are feeling, "Suppose someone decides I am not needed, that my program is not needed, or is not adequate?" These anxieties are real, and I think we must acknowledge them in order to work effectively together. People have been confused by all the jargon involved in credentialing; people have been placed in ambiguous situations because the outcomes in the future of the decisions made today are not all that clear; people have been honestly threatened by the possibility that some new standards and criteria for assessing their programs will emerge, and hence, they themselves may be rated "below standard." These ratings may carry with them the apparent judgment that the program should be abolished if there are insufficient resources to upgrade it to meet standards. These feelings will not disappear readily. We should acknowledge that they exist and try to deal with them openly.

Diversity - Those of you who remember Dorothy Nyswander's magnificent article on the "open society" will recall she stated that one of the major requirements for an "open society" was the support for diversity in the population. I hope, as we move towards some commonalities in our concerns for a generic health educator, we will consider the possibility that we may be moving ourselves toward a "closed society"--meaning a closed professional society. Yet we have people in our midst who are marching to the beat of a different drummer, and there may be a

temptation to throw them out or at least avoid them or ignore them. To me, this would be an absolute disaster for the profession. Without constant criticism from individuals inside and outside the profession, it will not be possible for us to grow. I hope we will always have individuals who can play the role of "Her Majesty's Loyal Opposition" to remind us of the need for change and the need to look at ourselves critically. We are fortunate that some of those individuals are here at this meeting.

Solidarity - Even the word "solidarity" has a special ring these days. It was clear from the presentation of Ray Carlaw that we need more solidarity; it was clear when Marian Hamburg told us that we did not speak with a single voice as a profession; but it was also clear in several of the discussion groups that we were, indeed, a "family" of institutions. We all have recognized the need to speak with a more united voice. The Coalition of National Health Education Organizations, which some of us helped to start in the early 1970s in response to the President's Committee on Health Education, has played a significant role in bringing the different factions of the profession into a more collaborative arrangement and in increasing the communicstion among groups with some divergent interests. I think, however, most of us recognize that the Coalition was just a first step, and that much more collaboration and eventually unification will have to occur.

Some of us have thought, too, about the need for more solidarity among the university programs themselves, for we have not had a unified way to respond to credentialing or, for that matter, a unified way to respond to anything. Should there be an association of university programs in health education? Should we have some regional networks of university programs? Should there be an organizational arrangement that brings us together to talk about mutual problems, other than our chance meetings at professional conferences and conventions? What will the advantages and disadvantages be of some more organized arrangement among us? These and a host of other questions emerge as we consider our own solidarity.

Achieving Health Objectives for the Nation

A major challenge for us here has been to review the national health goals and to determine where we fit as academicians and as health educators in working towards those goals. We have discussed in our small group meetings how we would attempt to articulate credentialing goals with national health goals, and I think most of us recognize there is enough in the document Objectives For The Nation to keep us meeting and working for years. We do not have time, however, just to talk about them; we must act soon. The groups will likely find many areas here that lend themselves to recommendations. Certainly, many of us see ways to incorporate components of that document into our teaching programs. Certainly, every student graduating from our programs should be familiar with the contents of the document. Certainly, we must demonstrate within a reasonable time how we can contribute to achieving national health goals. There are many specific suggestions in the document for research, documentation, and program development. The document, however, has not been written for our benefit as health educators--it is a "mandate" for the public health movement, and each health discipline will attempt to chart out specific areas for itself. What, then, will be the areas we concentrate on and how should we begin?

Looking Toward the Future

While it is probable that much of our focus has been on the document, in truth, it is time to think beyond the Role Delineation document and the Role Verification stage as well. No matter how it comes out, there will be opportunities for change. More important, in my view, are the stages that follow and the tremendous amount of work that must go into them. If you follow, on the flow chart, only the early stages forward of credentialing, you can see that indeed, the major work lies ahead.

As you move to Phase III, for example, and note that an educational resource document is to be prepared, it is clear that this document begins to set the standards for preparation, particularly the curriculum requirements in our institutions. If the document is not to be endorsed by the various professional organizations listed, i.e., AAHE, ACHA,

APHA, ASHA, SOPHE, SSDHPER, and STDPHE, what role will the institutions of higher learning play in the development of these standards? Do we wish to speak with one voice? With several voices? Do we ally ourselves with one or more professional organizations and let them speak for us, or will we speak for ourselves as academicians?

If, on one hand, we decide to stay out of the fracas, because we would be acting as judge and jury, what do we do when the standards for preparation arrive at our doorstep? We are provided with an opportunity for voluntary adoption. Is that the step we want to take? Or do we want to encourage accreditation, especially when we recognize all the forces operating against individual program accreditation? Administrators and faculties in colleges and universities are increasingly annoyed with accreditation procedures, expense, and logistical problems, with very few perceived benefits.

It appeared to me, as I listened to our speakers and as I have had a chance to read the literature on professional competency, that we are going to be increasingly pressured to prepare health educators in competency-based programs. The Federal Government is not providing its largesse because it is intrigued with the peculiarities of professions grappling with this part of the accountability question. It has an investment in assuring that quality health personnel are prepared, that there are objective ways to assess those personnel, that entrance and exit competencies are assessed, and that continuing competence is maintained. If the professional groups approve of standards, the competence leading to those standards will turn out to be our responsibility.

As one follows the development of competency-based programs, one finds eventually the profession is asked to explain why the competency is listed anyway. While it may be accepted because it was verified by practitioners, someone is going to ask, for it has been asked of all professions, "How do you know, when this function is performed, what the relationship is between the competency and the performance?" More important, they will ask, "How do you know that the performance of this activity leads to any of the several outcomes?" Given questions like

these, who, then, will provide the basis for the testing and measuring of the validity of competence statements? It would not surprise me if we as academicians will be expected to play a major role. Some questions to ask ourselves are, "How ready are we to develop and teach competency-based programs for preparation of health educators?" "How able will we be to measure those competencies on exit from the program, and on admission to the program?" "How do we know the program makes any difference?" and "How do we know that performance on the job at a competent level is related to successful outcomes?" I can assure you that we will be in very good company, for no other profession has yet validated its performance in relation to outcomes. Surely that is no reason, though, for us to wait for someone else to do it first.

Further down the road may come "National Health Education Boards," in which we will all have a chance to see how our graduates do, especially in comparison with one another. Then we will be asked, "Why do these differences occur?" and "Is the performance of the student on the 'Boards' related to how well he/she actually does on the job?"

As I look at the opportunities and options along the way, it appears to me that we can get actively involved, stand by in a "holding pattern," or ignore it all. What is urgent, however, is the need to consider the arrangements by which the academic programs will relate to each other during these next few years, as competency-based programs are required.

Young Faculty and The Future

I have been very much impressed with the numbers of young faculty members who have been able to attend this meeting. Those of us who are now into or close to the senior citizen ranks in health education are grateful for the contributions these younger faculty members have made here. It may appear to some that the "old-timers" hold the power and that the younger faculty must defer to them. In truth, the future belongs more to the younger faculty members than to the "old duffers," and it is the job of all of us in academic institutions to provide effective ways for young faculty members to help chart the future of professional preparation in health education. I would want to see as

many assistant professors and associate professors as possible on the various committees planning our future.

Some Areas to Consider for Recommendations

As I have listened here to what everyone has said, it seemed to me we would have suggestions and recommendations in a number of areas, for example:

(1) Those that relate to the present Role Delineation document itself, its formulation, and its wording, particularly as it is related to the next step in the Role Delineation Project.

(2) Those that relate to the stated specific next steps in Role Verification, and that involve consideration of additional steps, or alternative steps that someone may consider more effective or more useful to the extent that they are possible within the framework of the conference.

(3) Those that relate to the entire Role Delineation Project and all its planned steps, not just individual steps but, rather, the whole process--its time constraints, its mechanisms to accomplish certain objectives, or its resources.

(4) Those that relate to our roles as academic institutions and as individuals or collective faculty members in those institutions, concerned with the preparation of health educators not only in relation to the next steps but, more important, to the long-term implications.

(5) Those that relate to the large issues in credentialing that need to be considered at some point in time and to which many of us individually and collectively, as either academicians or professional health educators, have to respond in the future.

About each of these categories, it seemed to me, the National Task Force wants to hear from us.

We have come a very long way in this conference in a very short time. The time has been right for our meeting together; the conference arrangements have been superb for our making the most of our time together; and the group assembled has a wealth of knowledge and skill in the major topics being discussed. Let us now see how we can put this all together in specific action recommendations.

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RECOMMENDATIONS

WORKSHOP ON COMMONALITIES AND DIFFERENCES

Conference on the Preparation and Practice of Community
Patient and School Health Educators

February 15-17, 1978
Bethesda, Maryland

RECOMMENDATIONS

WORKSHOP ON COMMONALITIES AND DIFFERENCES

CONFERENCE ON THE PREPARATION AND PRACTICE OF COMMUNITY PATIENT AND SCHOOL HEALTH EDUCATORS

The participants presented recommendations for the future direction of health education in relation to preparation and practice of the total field, regardless of practice setting or speciality focus. These recommendations represent consensus on the part of the group and were viewed as positive action oriented steps to achieving a unified and acceptable approach for examining the preparation and practice of professional health educators.

RECOMMENDATIONS

- That each member organization of the Coalition assume responsibility for disseminating the proceedings of this Workshop. And that each group identify the implications of this Workshop for its own membership and explore the resources that it can commit to achieving the necessary follow-up to the Workshop.

- That the Planning Committee for this Workshop become a National Task Force on the Preparation and Practice of Health Educators. And that members of the Planning Committee continue to serve on the Task Force, subject to approval by the Organizations they represent.

- That the Task Force, including a representative from the Office of Education, be charged with the responsibility for developing a plan of action leading to a credentialing program within a specific time frame for the total field of health education. Specifically, the Task Force will:

  - serve as a liaison with health education organizations, and with pertinent government offices, including the Bureau of Health Manpower, and the Bureau of Health Education

  - establish priorities

  - seek funding to support a credentialing effort

- That the plan of action developed by the Task Force lead to:

  - a survey of field practice including a synthesis of existing research

  - a concrete statement of the State-of-the-Art of health education

- an assessment of health educator competencies
- development of performance criteria
- delineation of performance criteria
- delineation of core curriculum requirements for both entry level and specialized health educators

That government programs and private agencies with health education components require staffing by qualified health educators.

*February 15-17, 1978, Bethesda, Maryland

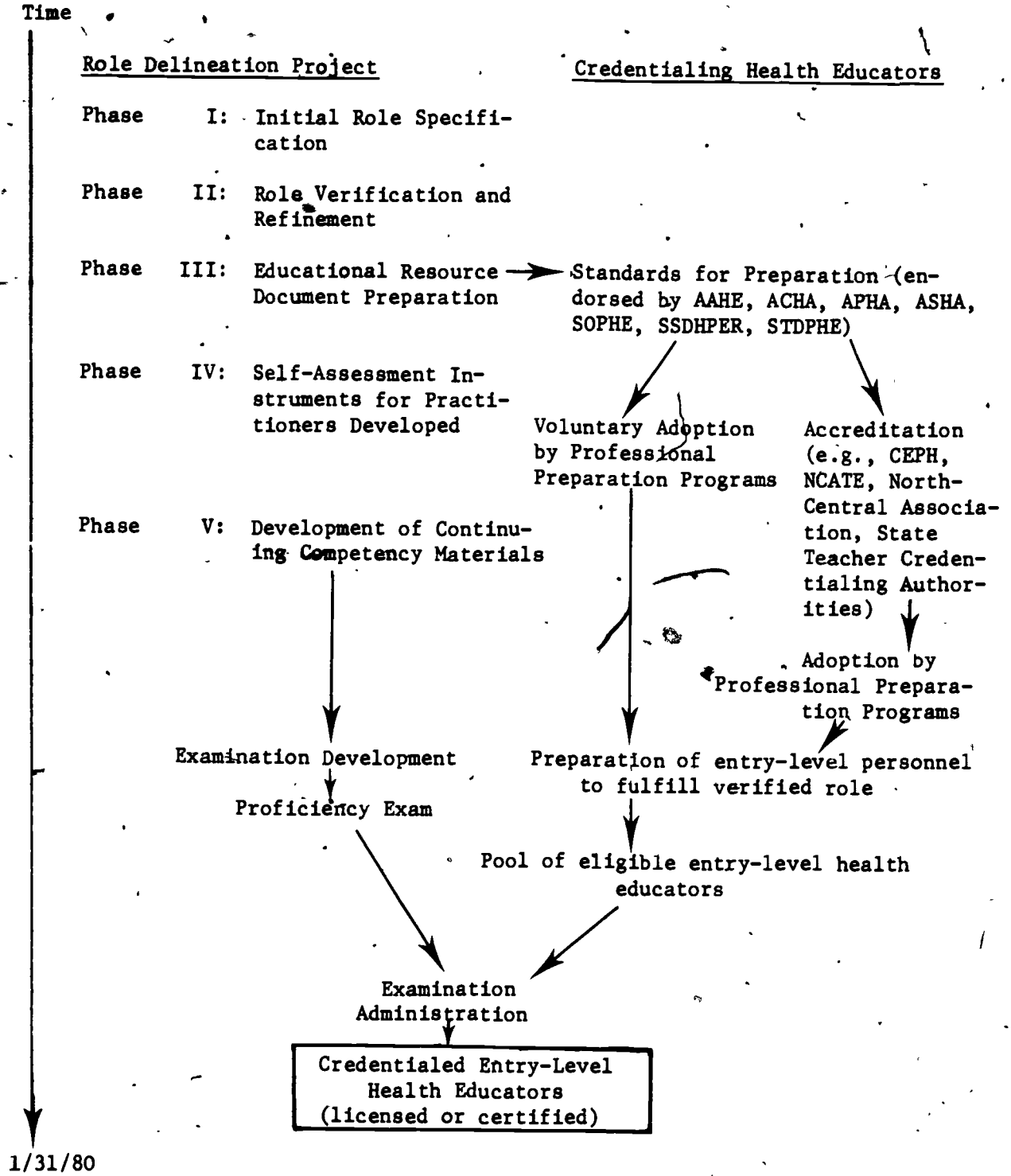
NATIONAL CENTER FOR HEALTH EDUCATION

ROLE DELINEATION PROJECT FOR HEALTH EDUCATION

National Center for Health Education

ROLE DELINEATION PROJECT FOR HEALTH EDUCATION

Relationship Between the Role Delineation and Credentialing Processes



CHRONOLOGY OF EVENTS LEADING TO NATIONAL CONFERENCE FOR INSTITUTIONS PREPARING HEALTH EDUCATORS

CHRONOLOGY OF EVENTS LEADING TO

National Conference for Institutions Preparing Health Educators
Role Delineation: Implications for Credentialing in Health Education

Birmingham, Alabama, February 5-7, 1981

February 1978	Bethesda Conference on the Commonalities and Differences in the Preparation and Practice of Health Educators.
March 1978	Formation of the National Task Force for the Professional Preparation and Practice of Health Educators.
September 1978	Procurement of support including funds from the Bureau of Health Manpower (now called the Bureau of Health Professions) to the National Center for Health Education for the initial phase of credentialing--initial role specification.
October 1978	Role Delineation Advisory Committee (RDAC) formed.
January 1979	Role Delineation Project Director hired.
February 1979	Role Delineation Working Committee (RDWC) formed.
January 1980	The final draft of the initial role delineation completed.
April 1980	Publication of a final draft of the "Initial Role Delineation for Health Education" by the U.S. Department of Health and Human Services.
May 1980	Contract for the second phase role verification and refinement awarded to the National Center for Health Education.
July 1980	Issue of FOCAL POINTS on "Health Education and Credentialing: The Role Delineation Project" published by the Bureau of Health Education and the Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine.
September 1980	Role Verification and Refinement Committee (RVRC) formed.
Aug.-Sept. 1982	Planning meetings for the National Conference for institutions Preparing Health Educators held.

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ACCREDITATION: Who Does What?

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--There are four national institutional accrediting commissions
--There are 39 specialized (programmatic) accrediting agencies, some of which overlap

...COPA is governed by a Board of 38 members representing institutional and specialized accreditation, national associations of colleges and universities, and the public. Seven major institution-based associations are represented on the Board: The American Council on Education, the American Association of Community and Junior Colleges, the American Association of State Colleges and Universities, the Association of American Colleges, the Association of American Universities, the National Association of Independent Colleges and Universities, and the National Association of State Universities and Land-Grant Colleges.

...COPA derives its financial support from more than 4,000 accredited or accreditation-seeking institutions through COPA-recognized accrediting bodies.

...There are two COPA-recognized specialized accrediting agencies of specific interest to health educators:

--The Council on Education for Public Health
--The National Council for Accreditation of Teacher Education

...COPA publishes COPA: The Balance Wheel for Accreditation, Organization, Membership, and Publications List, annual; A Guide to Recognized Accrediting Agencies, annual; and Accredited Institutions of Postsecondary Education, 1980; a quarterly newsletter, Accreditation; Project Reports and Occasional Papers on topics of special interest.

THE COUNCIL ON EDUCATION FOR PUBLIC HEALTH (CEPH)
1015 Fifteenth Street, Northwest, Suite 403
Washington, DC 20005
202/789-1050
Janet Strauss, Executive Director

...CEPH is recognized by COPA and the U.S. Department of Education to accredit schools of public health and master's degree programs in community health education. It also has preaccreditation authorization for graduate programs in community health/preventive medicine.

...CEPH assumed the accrediting activities of the American Public Health Association in 1974.

...CEPH is structured as an independent agency with corporate membership held by the American Public Health Association (APHA) and the Association of Schools of Public Health (ASPH). A board of eight councilors, including two public representatives, are appointed by the corporate members: three each by APHA and ASPH, with the two public members jointly appointed.

...Financial support comes from accredited schools and programs and those applying for accreditation.

...CEPH publishers Manuals of Standards and the Accreditation Process Manual.

THE NATIONAL COUNCIL FOR ACCREDITATION OF TEACHER EDUCATION (NCATE)
1919 Pennsylvania Avenue, N.W., Suite 202
Washington, DC 20006
202/466-7496
M. M. (Lyn) Gubser, Director

...NCATE is recognized by COPA and the U.S. Department of Education to evaluate and accredit programs that prepare professional educators for positions in K-12 schools for all grades and subjects. Included in NCATE accreditation are programs that prepare various school service personnel. Basic and advanced programs are reviewed.

...NCATE applies standards it has developed to colleges and universities seeking to establish or maintain accreditation. In its 1979-1980 list, 545 college and University programs at basic and advanced levels were accredited.

...NCATE represents ten constituent organizations: American Association of Colleges for Teacher Education, American Association of School Administrators, Council for Exceptional Children, Council of Chief State School Officers, National Association of School Psychologists, National Association of State Directors of Teacher Education and Certification, National Council of Teachers of Mathematics, National Education Association (Instruction and Professional Development), National School Boards Association, Student National Education Association. Representatives from these organizations make up the Council, which governs NCATE. There are four associate organizational members, in addition: American Personnel and Guidance Association, Association for Educational Communications and Technology, Association of Teacher Educators, and National Council for the Social Studies.

...NCATE was initially recognized as an accrediting body in 1952.

...NCATE publishes Standards for the Accreditation of Teacher Education 1979, an Annual List of accredited programs, and NCATE UPDATE, a quarterly newsletter.

DEPARTMENT OF EDUCATION
Office of Postsecondary Education
Bureau of Higher and Continuing Education
Division of Eligibility and Agency Evaluation
Washington, DC 20202

...While accreditation is a voluntary, private effort, federal recognition of an accrediting agency is a prerequisite to eligibility for federal financial assistance for institutions and their students under select federally supported programs. The U.S. Department of Education is responsible for recognizing accrediting agencies for the government's purposes.

..."For purposes of determining eligibility for Federal assistance pursuant to 20 U.S.C. 1141 (a) and other legislation, beginning with the Veteran's Readjustment Assistance Act of 1952, the U.S. Commissioner of Education (the Secretary of Education)...publishes a list of nationally recognized accrediting agencies and associations which he determines to be reliable authorities as to the quality of training offered by educational institutions either in a geographic area or in a specialized field, and the general scope of recognition granted to the accredited bodies."

The list is published in the Federal Register and as the Department of Education's Nationally Recognized Accrediting Agencies and Associations.

Compiled by Elena M. Sliepcevich, Department of Health Education, Southern Illinois University-Carbondale and Alan C. Henderson, Role Delineation Project, National Center for Health Education

December 1980

DEFINITIONS OF CREDENTIALING MECHANISMS

NATIONAL CENTER FOR HEALTH EDUCATION

Role Delineation Project

Definitions of Credentialing Mechanisms*

Accreditation - The process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards.

Licensure - The process by which an agency of government grants permission to persons to engage in a given profession or occupation by certifying that those licensed have attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected.

Certification or registration - The process by which a non-governmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association. Such qualifications may include: (a) graduation from an accredited or approved program; (b) acceptable performance on a qualifying examination or series of examination; and/or (c) completion of a given amount of work experience.1/

1/Taken from Report on Licensure and Related Health Personnel Credentialing, June 1971. DHEW Publication No. (HSM) 72-11. Washington, DC: U.S. Government Printing Office. p:7.

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