Overview of the 2006 NCHEC Advanced-Level Certification Feasibility Study Results: The Impetus of a Positive Legacy

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Through the 6-year National Health Educator Competencies Update Project (CUP), in 2004, the National Commission for Health Education Credentialing, Inc. (NCHEC), American Association for Health Education (AAHE), and Society for Public Health Education (SOPHE) completed verification of advanced-level competencies and subcompetencies for health educators. Along with this verification, it was recommended in the CUP report that NCHEC should consider implementing advanced-level certification to parallel advanced health education practice. Similarly, during this same period, the National Task Force on Accreditation (NTFA) (Allegrante, Airhihenbuwa, Auld, Birch, Roe, & Smith, 2004) recommended that entry and advanced levels of practice be distinguished. To glean health educators' input regarding advanced-level certification, an online feasibility survey study, under the direction of the NCHEC CUP Implementation Committee (Dixie Dennis, Chair; Kelly Bishop Alley; and Amos Aduroja), was conducted by Professional Examination Service (PES). This survey was available for health educators to complete online from October 10-29, 2006. The remainder of this paper will be used to present a summary and interpretation of the results of the Advanced Certification Feasibility Survey (henceforth referred to as the Survey), which was submitted to the NCHEC CUP Implementation Committee in January 2007 by Pat Muezen, a Professional Examination Service (PES) representative.

Results

Demographics for Survey respondents included the following:

- 1,578 health educators completed the Survey.
- The largest percentage of respondents (31%) were from the community work setting, with academia second (23%) (See Table 1).
- Most of the respondents (67%) were in the early-to mid-stage of their career as a health educator.
- The mean number of years that respondents worked as a health educator was 10.5.
- The highest level of education for 62% of the respondents was a Master's degree.
- 85% of respondents held the CHES certification.

Specific to Survey statements/questions, respondents overwhelmingly (no lower than approximately 60% to 80% across work setting, primary role, highest level of education, and current CHES status) reported that they believe the development of advanced-level certification will benefit the profession and is part of the role of an organization like NCHEC. Moreover, a similar percentage of Survey respondents reported that the anticipated benefits of an advanced-level certification would be useful as (a) a means for assessing knowledge and skills of health educators practicing in the field; (b) evidence of professional capability; and, (c) a lead for greater professional recognition. On the other hand, almost 8% of Survey respondents (7.8%) reported that there is no additional benefit for advanced-level certification because the entry-level CHES credential currently is not sufficiently recognized.

Survey respondents reported that either portfolio or scenario-based essay is the preferable assessment technique (55% of respondents assigned portfolio assessment a rank of 1 or 2 and 50% ranked scenario-based essay examination a rank of 1 or 2). In a Study Report summary statement, Pat Muenzen emphasized that portfolio assessment is a resource intensive undertaking that should not be entered into lightly. Moreover, it was revealed, through a January 2007 National Organizational for Competency Assurance Academy Online Portfolio Seminar, that portfolios are not suitable for certification, or summative evaluation, assessments.

Regarding payment for advanced-level assessment, 61% of Survey respondents reported supporting a fee of $150.00 or less, with 8% of those wanting to pay nothing. These fees, or non-fees, are well below what is needed by any professional organization to implement assessment procedures.

Specific to eligibility for advanced-level certification, results from the Survey revealed that 58% of respondents endorse requiring a combination of education and years of experience. Specifically, those requirements are Master's degree or higher and 5 years of experience OR Bachelor's degree plus 10 years of experience.

Although there are other Survey responses on which to report and discuss, the CUP Implementation Committee believes that the main consideration is how health educators responded to the statement, "I am personally interested in

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Table 1

Feasibility Study Respondents' Primary Work Setting

Work setting	n	%
Community	482	31
Academia	368	23
Health care	309	20
School	195	12
Business/industry	83	5
Other	141	9
Total	1,578	100

pursuing advanced certification." Specific to work settings, Chi square and subsequent post hoc analyses revealed that significantly more respondents in the school setting reported being interested in pursuing advanced certification than those in community ($\chi^2 = 10.03$, $p<.05$), academic ($\chi^2 = 10.80$, $p<.05$), health care ($\chi^2 = 5.21$, $p<.05$), and other settings ($\chi^2 = 4.59$, $p<.05$). In addition, compared to respondents in academic settings, significantly more respondents from the business/industry work setting reported being interested in pursing advanced certification ($\chi^2 = 3.88$, $p<.05$).

Of the 1,578 respondents, 49% reported that they agree or strongly agree, and 29% reported that they disagree or strongly disagree, with the Survey statement about interest in pursuing advanced credentialing. Another 22% of respondents reported that they neither agree nor disagree (undecided/neutral) with that statement. According to Pat Muenzen, that percentage of undecided/neutral is exceptionally high among members who complete opinion surveys regarding advanced credentialing (personal communication, January 12, 2007).

Interpretations

One possible implication of the higher-than-normal percentage of undecided/neutral among Survey respondents is that, with NCHEC marketing techniques, the percentage of health educators who favor advanced certification could increase in a relatively short time. A scenario in which more undecided/neutral health educators move toward disagree and strongly disagree, however, is also possible. Lastly, a factor other than lack of marketing may underlie undecided percentages among respondents.

The response rate is the single most important indicator for how much confidence can be placed on survey results (Monette, Sullivan, & DeJong, 2002). A low response rate can damage credibility of a survey, because results are less likely to represent the target population. In theory, any response rate less than 100% reduces the generalizability of the results (Torabi & Ding, 1998). Monette, Sullivan, and DeJong, authors of the text, *Applied Social Research*, reveal that a response rate as low as 20% for a questionnaire is unacceptable. According to Earl Babbie (2004), author of many texts on social research, to be considered "good," a response rate should be roughly 60%. Specific to online surveys, according to online survey analyst, Michael Braun Hamilton (2005), half of online surveys receive a 26% or better response.

To determine the response rate for the Survey, the number of health educators who were invited to complete it is needed. Although the exact number of health educators is not known, the following organizations had links wherein visitors could complete the Survey—AAHE, SOPHE, and NCHEC. AAHE sent e-mail invitations to AAHE members (approximately 5,500) to participate in the Survey; SOPHE did likewise to national SOPHE members (approximately 1,800); and, NCHEC did likewise (6,674 CHES holders in October 2006). Also, access to the Survey could be obtained through the NCHEC Website, which is available for anyone to peruse (CHES, non-CHES, and from any organization). Complicating the issue of determining population size is that some health educators belong to more than one organization and, therefore, received multiple invitation links. Other health educators may not have belonged to any professional organization and, as a result, no invitation or link to complete the Survey was available. What is known, though, is that of the 6,674 CHES holders, 1,343 responded to the survey (20% response rate); of the 5,500 AAHE members, 437 completed the survey (7.9% response rate); and, of 1,800 SOPHE members, 589 completed the survey (32.7% response rate). The remainder of respondents reported membership in APHA, ASHA, and/or other. These low response rates are particularly troubling given that response rates typically are higher with electronic surveys than other survey types (Gedney, 2003). Also, these response rates are cause for concern because the response rate for the CUP project (wherein it was revealed that health educators practice at an advanced level, which became the main impetus for gleaning health educators' opinions regarding an advanced-level certification for those who practice at that level) was 70.6% (Gilmore, Olsen, Taub, & Connell, 2005).

Conclusions

Pat Muenzen explained that successful financial implementation of an advanced credential is unlikely because only approximately 50% of respondents reported being interested in pursuing an advanced certification (personal communication, January 12, 2007). Also important to acknowledge is that actions do not always follow intentions (e.g., being interested in pursuing advanced-level certification). Nevertheless, the CUP Implementation

Committee believes that it is not wise to allow fewer than one-third (29%) of Survey-responding health educators (the percentage of respondents who currently reported not being in favor of pursuing advanced certification), and the 22%, who were undecided, to dictate what steps are taken regarding advanced certification. Committee members wondered if the opinions of the many health educators who did not respond to this Survey hold different views about advanced-level credentialing from the ones who responded. And, although many questions remain about the method of delivery and eligibility requirements, preliminary dialogue between NCHEC leaders and AAHE and SOPHE leaders indicates support for implementing an advanced credential. The CUP Implementation Committee agreed that health educators are in a similar position as Machiavelli, who was quoted in Orlans (1975) as saying that it is both difficult and uncertain to take the lead in introducing of a new order of things.

Despite the possible difficulty and uncertainty to launch something new, on April 28, 2007, the NCHEC Board of Commissioners voted in agreement with the CUP Implementation Committee and the majority of the 1,578 Survey respondents, who reported that the development of advanced-level certification will benefit the profession and is part of the role of an organization like NCHEC, to proceed with implementing advanced-level certification. Immediately, the CUP Implementation Committee was charged with finalizing decisions and actions regarding the following:

- Eligibility requirements
- Name of the credential
- Type of assessment
- Cost analysis
- Continuing education opportunities
- Marketing strategies, including those specific to the existing credential

Indeed, health educators are living in an exciting time of positive professional growth. As George Bernard Shaw, freethinker and Nobel laureate, once explained, it is the future that defines legacy. In the making of a positive legacy for health education, the CUP Implementation Committee welcomes input from all health educators regarding any aspect of the advanced-level credentialing project. Comments should be sent to llysoby@nchec.org. Also, interested health educators should check the NCHEC Website (http://nchec.org/) for any updates regarding advanced-level certification.

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