

## Is a Nurse a Health Educator?

### Objectives

- Describe the history of the CHES certification
- Identify the pros and cons of CHES certification
- Compare the similarities and differences in the delivery of health education between nurses and health educators

### Eligible for 2 CHES: CEC

- Read this document
- Listen to the audio recording
- Complete the evaluation



TWatson

Ok... I am not sure if this will stir the pot as much as Alabama Texas... But here it goes.

A few months ago I posted a comment in support of SOPHE and AAHE merging (actually AAHE leaving AAHPERD). I commented that I would like to see (before my physical or professional demise) a health education profession that is licensed in the healthcare field.

In order to get that far I think it important to discuss the benefits and barriers to licensure. I have read posts before about the CHES credential and why some in the field do not think it valuable... Perhaps it is because it is not required... If that is the case, licensure would solve it...

At any rate... A few questions. Please respond to the whole if possible

1. Why shouldn't we as a profession require a minimum education and licensure process?
2. What difficulties do you see with this?
3. Do you think that the health education profession should have a consolidated professional association to advocate for our professional goals?
4. What are the "profession's" goals? Not what we will do for others, but how to advance our field?
5. What are you willing to do (or already doing) to promote health education to the level of our sister professions like nursing, physical therapy, social work, and teacher education?
6. Where am I wrong here (the cocoo bird in the chicken house)?

The only way we make progress in the profession is by finding value in the journey, feeling like the journey matters, and overcoming barriers (I think this is a little like the Health Belief Model?????)...

So speak up... especially those that just read and delete... it will only take about 10 minutes of your time.

P.S. I would also like to have a lunch discussion at SOPHE this year to brainstorm and hammer out differences regarding this process.... Maybe even identify some next steps.

McMillan

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Tyler, I am going to respond to some, but not all of your questions. Although I am CHES certified, I have come to the conclusion that the criteria to become a CHES either need to be strengthened to the standards of a licensure or eliminated. When I discussed the CHES certification with my department chair, her response was and I tend to agree, "your credentials should stand for themselves."

2. What are we doing as health educators that require us to be licensed? I also don't agree that medical assistants are required to be licensed.

3. I do agree that having a consolidating organization rather than several would help to better serve the profession. I have been a long-time member of APHA and have had no problem getting enough resources to keep my skills current and up-to-date on health education related issues.

I have had a difficult time understanding the need for the plethora of certification programs that have cropped up over the past 10-20 years. When you get certified, you spend time, energy and money to maintain that certification, but I haven't seen it translate to higher salaries, and increase in demand for your skills and abilities, or more respect.

Carrio

I think it's way overdue we as health educators not having any type of requirements for licensure. It's about time we step up to the plate and advocate for this! I personally believe CHES is too weak and almost a joke!

Basically any bachelor's level candidate can pay the exam fee, pass the test and bingo be "CHES" certified...LOL

We need something that is standardized and carries more academic and professional "weight" across the board. I know of people that call themselves "Health Educators" and are supposedly CHES certified with no college education. That really dilutes the profession and minimizes those of us that have bachelors and masters academic training in Health Education and Health Promotion. Just a thought.

Hallsky

Has there ever been an interest among health educators to push for CPT/ billing code? If we are talking about gaining the same respect and/or level of professionalism as sister professions in PT and Nursing and even Dietetics, then we should be talking about a medical billing code for our services as an allied health profession.

I am not fluent in Medicare and Medicaid billing codes, but here is an example from Alabama's Medicaid reimbursement for health education services. [http://www.medicaid.state.al.us/documents/Billing/5-G\\_Manuals/5G-2\\_Provider.Manual\\_Oct.2009/Oct09\\_30.pdf](http://www.medicaid.state.al.us/documents/Billing/5-G_Manuals/5G-2_Provider.Manual_Oct.2009/Oct09_30.pdf)

I agree that a licensure program would be beneficial to advancing the profession in conjunction with a reimbursement scale for services.

Zorrilla

I agree with Sarah. (Hallsky)

To add to what I said earlier, I cannot bill for my services, except for family planning because my state (California) allows it for anyone who works at my clinic (medical and health education depts). Thank you.

JLager PhD

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I totally agree with this!!!! We need to be able to bill for our services. My Deputy Director believes in what we do but I cannot expand my services or space because what I do is not billable. This would be a huge step for health educators and what we do, especially for those in hospitals, doctor's offices, and community health centers.

JLeake

It's interesting we are having this discussion about CHES this morning. One of our local health education teachers sent an email to me this morning recommending a video to preview for use in our health education classes. The description of the video sounded interesting. When I read the attached review and then noticed that the author (Tina M. Penhollow) was a "CHES," my interest was aroused even more. It gave me the feeling that I could put additional trust in the reviewer's comments (kind of like we were on the same "wavelength.")

From the last National Commission for Health Education Credentialing, Inc. (NCHEC) newsletter I received, I learned that NCHEC will soon introduce an advanced-level of certification called the Master Certified Health Education Specialist. This seems like a move in the right direction. Those of us in school health education, teaching in school systems in Maryland, do have state licensure, so I guess another form of licensure is not as important to me, although I can see where it would be important to others. But CHES spans across all facets of the profession – school health, community health, higher ed., corporate, etc., so I value the credential and do not see it as a joke.

MFulop

So we have the utter failure to reform the health care system, an economy with double digit unemployment rates, wall street still gaming the system with our money, a complete failure at the global warming talks, an expanding war in Afghanistan, Civil rights continuing to be eroded, and as health educators it takes the single recurring question of Credentialing/Licensure to get the list talking again?

Haven't we been down this road or should I say around this circular track? Again and again? CHES is a money maker for NCHEC but I know of no cases where anyone gets a pay differential because of CHES. A Master's level CHES would be as silly as CHES itself and you can count this former CHES as a critic.

Tyler (Watson), I am not sure what licensure would get us any more than what CHES would get us. As it is, the health industrial complex continues to dumb down all Health professions. We don't need 4 RN's just 1 RN supervising 4 LVNs or CNAs. We don't need a RN, certified asthma educator working with Asthma patients, we only need a paraprofessional (Indeed, I could give a detailed real live example of health insurance bureaucrats saying directly, "you don't need a nurse working with high risk asthma patients, that work can be done by paraprofessional"). You get my point. so, in this dumbing down environment we think that we can take the wide-ranging and generalist skills we lump together and call health education and expect to push forward a license? I don't see it.

Billing codes for specific health education functions? Might help in bringing in revenue to give health educators more job security but again, the general rule is that billing codes are typically reserved for licensed professionals except when you can prove the "dumbing down" defense that billing health educator time is cheaper than billing nursing time, then you might make some headway.

Chicken? egg? or should we be talking about the failure of health care reform and its effect of once again marginalizing health education?

Cissell

Mark Fulop, The problems you describe are important but daunting ones. They are worth discussing, but the

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fact that they are bigger and more difficult to solve probably contributes to less chatter on this particular listserv.

Tyler, after the first phase of the initial Role Delineation Project (1978-80), which you may recall was directed by Dr. Alan Henderson with oversight by the National Task Force on Preparation and Practice of Health Educators, there was considerable discussion within our profession about which credential we should pursue.

Licensure is a legal credential, which requires getting enough political muscle to sway legislators to require it. Registration is establishing a list of eligible prospects to be hired for a particular job classification; it requires an agency or other employer to establish it, delineate the policies for using it and maintain the list. Certification is a voluntary credential that the profession can use to assure quality of the professional it certifies.

As members of the National Task Force on Preparation and Practice of Health Educators was determining its course of action in 1988, we determined that health educators did not have the collective political muscle get laws passed to require licensure across the country. Further, we did not see it as practical to pursue immediately getting registration procedures set up in every state. The most practical action was to establish the National Commission for Health Education Credentialing and pursue certification. The starting point was with the entry-level health educator.

Subsequently, CHES has become a recognized credential which is required by a fair number of employers when recruiting health educators. As early as 1990 at Texas Woman's University, a VP for academic affairs required that all new faculty members hired in the Department of Health Studies have CHES. Also, I have seen many position vacancy announcements placed by other universities and healthcare entities that indicated CHES is preferred or required.

In 1999, the standard occupational category was established in the US Department of Labor for health education. This means that health educators get priority when a federal agency is recruiting for a professional with health education knowledge and skills.

Possibly, health education has matured enough in the past 20 years for more intense dialog about prospects for pursuing licensure.

Sorry for the length of this message, but it seemed necessary to cover the topic minimally. I will add some other thoughts in separate messages.

Pinilla

Good afternoon,

This is my first post, but I have enjoyed reading your posts for several months now. I just received my MPH in December of '09 from the University of South Carolina and i am currently looking for a job! I was planning on registering tomorrow for the April CHES exam, so this topic came at the perfect time. The majority of the posts I read on the listserv come from individuals who are CHES certified, however, I have been receiving emails from my school which talk about the new "Certified in Public Health" (CPH) exam. The CPH is sponsored by the National Board of Public Health Examiners, so I'm assuming it is pretty good. I believe the main difference between the two exams is that with the CPH you have to graduate from an accredited school of public health. For a new graduate, which set of credentials would be better to have? I know CHES is probably the most well know, but from what I have read today, it does not seem to carry much weight anymore. Also, do you think employers are more likely to hire a person who is CHES certified or CPH certified? Thank you for your time.

Tyler

Bill (Cissell) as always... it is nice to have a historian to help navigate waters. Thanks for your comments.

Mark F, I appreciate your thoughts. I do think that healthcare reform is important. And what you term as a failure I am apt to celebrate as a success because the 2000 pages of "reform" debated in Washington DC do

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very little to address healthcare reform... it simply changes insurance rules and does little to lower costs, improve outcomes, and increase access to critical "sick care services". There was a glimmer of good in the bill... prevention would be a higher priority with more federal money spent on prevention services...

With more money in the future hopefully being spent of valuable and effective prevention measures that will improve health outcomes, isn't even more important to have some kind of differentiator so that money flows to those with specific training in prevention, programming and evaluation of outcomes?

Pejsach

Certification,... licensure .....CHES..... what about a national organization fighting for the licensure and fully, wholly, supporting certification so it matters? I believe we need THE org first, then the licensure (look at the history of other health professions and their orgs!). What are we waiting for?

Took a look at yesterday's Sunday NY Times listing for public education jobs. None listed health education.

Man, oh man....it's like "deja vu all over again."

With love and understanding, I am, Yours truly,

Froehle, BS, CHES

According to the National Bureau of Public Health Examiners website (FAQs):

"How Does This Exam/Credential Relate to CHES? The ACHE Diplomate? Being a Registered Sanitarian? The exam will cover general information in the five core areas of knowledge basic to public health and cross-cutting areas relevant to contemporary public health. The exam will not delve into more specialized areas covered in the CHES, ACHE and other exams." <http://www.publichealthexam.org/FAQs.cfm>

Contrary to popular conjecture, it requires at least a bachelor's in health education and 25 semester hours (or 37 quarter hours) of health education curriculum (vs. generic public health) to be eligible to sit for the exam. Master's level public health coursework does not necessarily provide preparation in the seven areas of responsibility of "health education," so not everyone with an MPH is eligible for this "weak" credential. No "joke."

Toland

Good afternoon!

I agree health educators need a organizational "power" behind the focus! What are we waiting for?! However, I am CHES and I wouldn't say it was a "Joke" to pass the exam you must know the required material and with most occupations there is continued learning after graduation, certification, licensure etc.

Hallsky

CHES may be preferred on many job postings, but often I see "RN required" for many health education positions. Why is this so? I believe that it's a reimbursement issue. If I'm a hospital administrator, I want my workforce to be able to earn their keep.

Simply put, while valuable and shows that a level of competency is assured, the CHES as a credential doesn't offer a way to cover its own costs in as efficient a manner as other occupations via licensure.

Cissell

Sarah (Hallsky), You are right. In my personal experience, I found that many employers want to hire RNs to educate about health. Also, I found that a larger number of RNs preferred to be educators, particularly after they had done several years of clinical work. I directed the Texas/Oklahoma AIDS Education Center for a couple of years. My boss was a nurse, my assistant director was a nurse, and, when we added an health education position, my boss insisted that we hire a health educator who was an RN.

While I was on the graduate faculty at Texas Woman's University, and I suspect this pattern continues, the largest discipline represented by applicants to our PHD and MS in Health Education (later renamed Health Studies) programs was nursing. Of course, TWU produces the most nurses of any university in Texas, so there was a large pool of nursing alums of TWU. The explanation of why nurses were applying for our graduate programs rather than the nursing graduate programs was that they wanted to be educators rather than clinicians or clinical supervisors.

Toland BS MA CHES

William (Cissell), I feel employers want to hire RNs because of their clinical back ground and specific health related expertise. Also, in my opinion, this does NOT make them better or more qualified health educators but does initiate a "state" license which provides a document for topic intelligence.

I express to all of my Health Science students to enroll in as many science classes as possible as well as Medical Terminology and A&P (Anatomy/Physiology).

Until the political arena, medical industry, media, and citizens realize prevention is the "BEST" answer for better health, lowered health care costs and improved quality of life, there is going to be a need for health educators to strive/fight for occupational recognition.

Case in point, I reside in the southern part of Georgia (stroke-belt) where prevention is a "dirty" word until a person is in tertiary status...then a miracle drug is supposed to cure all. The mentality "we" are up against.

Thanks,

McMillan

There are several vacant positions in the DC area for nurse health educators. Most of them are in hospital or similar clinical settings. In some job descriptions, it is clear that the applicant would be performing duties that are consistent with the skills and abilities of a medical professional i.e., patient care, in many others, the work is typical of the type that most health educator/health promotion professionals perform.

Below is a job description for a nurse educator at a DC hospital:

The Healthy Foundations Nurse Health Educator will serve as a key-player in the organization's effort to reduce infant morbidity and eliminate infant mortality. The professional will provide comprehensive health education services to high risk pregnant women in the Health Foundations program.

She/he will serve as a medical liaison who provides in-home assessments and referrals for high risk prenatal and postnatal participants. The nurse will work closely with physicians, social workers and other staff to ensure Health Foundations participants receives a continuum of services. He/she will supervise family support workers. Associate's degree in Nursing is required. Bachelor's degree is preferred. Approximately one to two years of progressively more responsible job related experience. A license as a registered nurse in the District of Columbia is required.

Schalk, R.N., M.Ed.

As a health educator/registered nurse, I thought I'd add my perspective...

I think, often, hospitals like to hire nurses to do health education because an R.N. may imply more clinical background and/or more credibility. I know that's not always an accurate assumption, of course. The bulk of my education and most of my experience has been related to health promotion and health education, not nursing. However, more than once, I've had patients/families look at my name tag and say, "Oh... you're a nurse... let me ask you this..."

Health education is certainly within the scope of nursing practice. Even clinical nurses teach as part of their daily work. If a particular position includes clinical nursing/patient care, then it may very well be appropriate to recruit only nurses. However, I think sometimes (particularly hospital-based) positions are limited to RNs when, in reality, a health educator may be better qualified/better suited for the position. I'm not sure it's entirely a reimbursement issue since most of nursing practice (education or otherwise) is not billable/reimbursable.

I agree with the observations of others:

\* many bedside nurses choose to move away from direct patient care after they have "done their time" at the bedside for a number of years. A job as an educator is attractive for a number of reasons.

\* many nurse managers prefer to hire nurses to do health education, again for a variety of reasons.

My personal bias (because I am first, a health educator and second, a nurse) is that being an outstanding nurse doesn't necessarily make someone an outstanding educator. While there is some overlap in the skills, if an employer is seeking an outstanding educator, they should look for an outstanding educator, whether or not they also happen to have "R.N." behind their name.

Just my .02 worth,

Larson, PhD

This truly is a topic you can set your bi-annual clock to. It comes around, and comes around?and frankly, the discussion is getting old.

If CHES was going to have an impact on the profession (i.e.

credibility, notoriety, justification, respect, payments, salary, etc) it would have begun to accomplish that now after 2+ decades. But it hasn't, and it won't. The only people who know what it is, the history, the original intent, or care for that matter, are elders in the discipline.

Someone asked in an earlier post, What do we do that no one else does?? And like hundreds of my faculty colleagues I have dutifully answered that question as they have: Any monkey can deliver content.

Stand in front of a group and tell them this is HBP, this is what it does, these are risk factors? It's easy. CHES shows that we are multi-dimensional, have met a myriad of competencies, can complete assessment and evaluation, are a resource to the community; have the breadth of content knowledge, etc, etc, etc? The issue?? No one cares!

Entities that will dedicate the resources and time to actually do what we train health educators to do are extraordinarily rare. So the result is that we end up being the monkeys. Why is School health practically in the morgue? Because schools won't commit to a CSHE approach, so 90% of all the training for the health educator is wasted. What's left is content only, and once again, the monkey can do the job. At that point you might as well just read a book, you may not even need the teacher.

Why RNs? Because they can spend 95% of their time being a nurse, and 5% being the content delivery mechanism; why pay a fulltime health educator to do 'content only' when anyone can do that? Again, while some nurses go beyond basic content, most do not, and the reason the find "education attractive" is because it's 8-4, not 12 hour shifts, and the stress level is way down. It is rarely because of an internal desire to educate the

masses... several years in the hospital corporation taught me that little fact.

Now, before you start firing off emails asking why I even stay in the profession, don't confuse frustration with this issue with lack of passion for the profession. It's just the opposite. I sit at my desk and wonder how we let ourselves become so fractured. In fact, I brought the 'unification' issue up to a colleague at another school and she said 'NO WAY, school health is not the same as anything else, we need to stay on our own.' And you all have heard the same thing about school vs. public vs. worksite vs. community. I don't believe it for a minute. You either believe in what we stand for as a discipline or you don't. The rest is semantics. So the professional organization issue on the table must be addressed. And while I don't think CHES had met the needs of the profession, with a unified professional organization, the certification must then evolve into meeting the needs of everyone in the organization. The power comes in the numbers and voice. No small challenge, but the NCHEC powers that be should probably start thinking about this, because I think in the next 10 years, its going to be a necessity.

We are better and stronger than our communities know, and that's a crying shame. I have rambled on long enough--sorry.

## DAY 2

SHarrington, DNP, MS, RN, CHES

I wanted to weigh in on this for I feel that I can see both sides. I am a CHES and an RN - my associates, bachelors, and doctorate are in nursing, where I worked in intensive care, open heart, recruiting, school health, disease management, and in the Air Force. My masters is in health services/wellness promotion where I earned my CHES - and found my passion. My doctorate focused on the business and health care management of health promotion. Since completing my masters, I have worked in health promotion and consider myself more of a health promoter rather than an RN. I have had fabulous health promotion leadership opportunities where I (with an interdisciplinary team) were able to make significant community impact. I say all of this to show I have the education and experiences in both nursing and health education/promotion.

Now to the point: Nurses (including me when I was preCHES) think they know health promotion - but what they know is health education on the individual and on the clinical level. And I say health promotion to differentiate it from health education. Health promotion is much more comprehensive. In addition to Prochaska's Stages of Change and the Wellness/Illness Continuum, health promotion includes implementing the socio-ecologic model and using social marketing, just to name a few of our "theories". Personally I feel the biggest difference is our ability to implement the socio-ecological model and social marketing - looking at family, community, social environment, and policy to implement change on a broader focus. Nurses look at the individual, and they are good at it. And it is fun and "attractive". But they aren't health promoters.

As one person said, and I agree, school health has never reached it potential because those who hire are not aware of our potential. They are only aware of the health education they have been exposed to - that of nurses or of the gym teacher teaching health. (Of course, there is another bias held by school districts, one towards an education degree to teach. I wanted to teach middle school health education in Maryland but was told I had to had a teaching degree first, but that is another story and another soapbox).

Nurses are health educators. Gym teachers are health educators. We are health promoters - promoting health in so many facets on so many levels, not health educators.

But nurses and those who do the hiring aren't aware of the difference because they haven't been educated in HP and don't know the scope of what we can do. (It was a real eye opener to me 10 years ago).

What we need to do is let others know what we can do as health promoters. We need to focus on how we are different - how we can implement change on multiple levels and social market.

One way to do this it to focus our research on outcomes and showing how we make a difference. We need data to show our efficacy. Talking data gives "legitimacy" to our profession.

Let me share with you one small example. Our health promotion team was able to show monthly outcomes to the executive board (along with the medical and QA staff). Initially, we were not part of the monthly report/presentation, but we pushed to become included and "show our worth". (And I don't mean how many attended our programs, but real change/improvement). A colleague of mine (Jim Grizzell) was able to adapt a study and develop a calculation that showed how much tobacco users were costing the Air Force - more importantly, he was able to use it to drill down to each unit and was able to show a squadron commander how much tobacco use was costing each individual unit in actual dollars and lost time. By doing this (and implementing other health promotion community changes such increasing the number of tobacco free areas), our team was able to decrease the total number of tobacco users at the military base (and cost per military squadron). We were able to gain respect and then show what we could do, allowing us to implement the community and health policy changes with true leadership support and enthusiasm. I feel that attaching data and dollars outcomes to our value is the key (and the challenge).

We are health promoters, not health educators. Let the nurses educate clinically - they are good at it. Let's focus on health promotion and community/policy change.

In my opinion, we need to get the word out and show how we make a difference - we don't need another certification. We need outcomes and data.

I am sorry if I offended anyone, for that was not my intent, but thanks for "listening" :)

JChase, M.A., CHES

Ms. Hallsy makes an excellent point. If the profession of health educators whether school-based, community-based, or otherwise expects to be respected as university trained health behavior specialists with an opportunity to receive CPT reimbursement, than more than a four letter designation (CHES) may be required.

As a health educator I certainly do not consider my expertise to qualify and meet the standards established for RNs, MDs, PTs, RDs, and the like.

Although many undergrad programs, such as the one I matriculated through found health educators in the same courses as Med Techs, PTs, OTs, RNs, RDs, etc. as a health educator, I was neither trained nor licensed to deliver that level of clinical service.

Similarly although many clinicians do receive some training in behavioral health, I would expect them to defer to the experts in behavioral health: that is health educators.

Until the profession of health education, whether school-based or public /community-based advocates for itself as distinguished professionals, establishes state level criteria based upon CHES or similar national guidelines, we will not be recognized as such.

Mkittleon, PhD

Karl's (Larson) comments are well worded. In addition, we have the problem that most schools don't hire qualified people to teach health. Rarely do we see a major in health education get a FULL time job teaching health. Most of the time, people who teach health have, at best, a 'minor' or an 'additional teaching certificate' teaching health.

MGoldsmith

I appreciate Karl's comments for all of us have felt the frustration of being underutilized and unrecognized as a profession. That being said I also think it important to realize that credentialing has had more of an impact than many people are aware of. First and foremost it has brought a level of credibility to the profession by assuring that CHES have demonstrated mastery of competencies that have been identified by the profession and employers. CHES has also been written in job announcements as either required or preferred for employment. While it may not have accomplished all that we hoped it could let's not lose sight of what it has accomplished. Further, we must realize that credentialing is not the end all solver of all of our profession's issues.

We have many challenges to tackle. School health education is still a joke in many schools and doesn't even exist in many States. Public health education remains at the bottom of the totem pole even though it has huge potential for bringing down health care costs and improving quality of life.

My mother (who is now 90) always said that necessity is the mother of invention. I think we are getting very close to a time where we will be an essential player in health care reform and bringing health care costs to a manageable level. Our challenge is to stop lamenting what isn't and to start planning what can be. In that way when we get to sit at the table we can bring innovative ideas, show the potential of health education and earn the respect that we truly deserve.

Like I tell my students there are many miracles in this world but none greater than the potential that lies within each of us as individuals and collectively to do great things. Progress is not measured in the small accomplishments of each day but rather the evolution over time of what we do. Keep positive, use your potential and if we work together we will get to see our goals achieved. Peace and happiness to you all!

WCissell PhD

Karl, Given that the topic of credentialing occurs frequently on this listserv probably means there are enough subscribers who care to bring it up periodically. I strongly disagree with your suggestion that only elders like me know and care about credentialing and the history of credentialing in our profession. If you read The CHES Bulletin, you will find that many of the juniors of our profession are engaged in credentialing work.

Suzy, I appreciate your informative post, but disagree with you about the definitions you apply to health education and health promotion. This is probably largely based on our different perceptions of the breadth of the two concepts.

A historical note is that in about 1978, congressional aides were preparing a bill to be sent to the committee proposing legislation to support a health education initiative. They wanted to be sure it went before the congressional committee addressing public health rather than the one addressing public education in the federal budget. Fearing that the proposed legislation would be misdirected if the term health education was used, these aides substituted the term health promotion for health education. Lawrence "Larry" W. Green is more familiar with this event than I am and can describe it more accurately.

My point is that health education is the broader discipline and health promotion is one aspect of health education. Promotion is something developed in marketing to inspire enthusiasm about a product by prospective customers. Health educators using the strategies and tools of health promotion do the things you described as the realm of the health promoter. The theories and models you perceive as those of health promoters are all appropriate to health education. Health educators, collectively, have the responsibility, the knowledge and the skill sets to pursue improvement of health within the individual, group, community, or population.

To be successful health educators, collectively, need to educate legislators to get appropriate health and safety laws passed, educate law enforcement to get the laws properly enforced, educate other health professionals to understand and appreciate prospective and preventive health improvement and disease prevention, and educate people, through schools and colleges/universities, community settings, worksites, clinical settings, or mass communication, to act in a way that increases the potential for optimal health status.

Since the 1970s, there has been a strong effort to supplant the identity of the health education profession with health promoters. I believe this is misguided. Health education is broader than health promotion and this is why The National Task Force on Preparation and Practice of Health Educators developed the Certified Health Education Specialist credential rather than a certified health promoter credential.

I expect this will fuel additional posts. Hope it does not frustrate Karl too much.

MScaffa

Wow this has been a very interesting discussion to follow. I think one of the main issues we need to resolve is terminology. It seems to me that many of us use the terms health promotion and health education differently. I suggest using the WHO definitions as these are widely accepted. The WHO sees health promotion as the broader term and health education as one strategy for health promotion. If we cannot agree on terminology and definitions we will go no where. For example licensure laws require very specific definitions of the scope of practice.

see the WHO Health Promotion glossary

[http://www.who.int/hpr/NPH/docs/hp\\_glossary\\_en.pdf](http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf)

MScaffa

I am pleased to see nurse health educators responding to this question. I am an occupational therapist (MS)

and a health educator (PhD). I thought when I entered the doctoral program that I knew health education because I was trained to educate patients in my MS program in OT. I believe many nurses think the same way. However, nothing could be further from the truth.

Health education/community health required an entirely new set of lenses, theories and interventions. I believe that trained health educators are better at health education even in clinical situations than nurses and allied health professionals without health education training. The main drawbacks I saw in the health education curricula were limited exposure to anatomy & physiology, medical terminology, chronic disease pathology and mental health issues. As an allied health professional, I was better able to communicate with physicians and other health care providers than a health educator would be. If you want to work in the medical arena, you need to speak the language.

DKocisko

Bill, I am an RN and will have my Master's in Nursing (focus in Nursing Education) this June. I was previously in a Health Education Program and was pursuing my CHES. I changed majors after this MSN, nursing education degree popped up at Cleveland State University. I changed because I recognize that the MSN is more marketable. With that being said, I feel that the Program Planning/Health education classes were excellent and even better than the nursing classes that were comparable.

BMyers

I was so glad to read the discussion about RNs and health education. My preceptor for my MPH was the ONLY health educator for miles and happened to be an RN as well. I worked at a health department at the time, as a registered sanitarian, and as soon as I got my MPH and CHES I was "used" as a health educator without getting the pay or the title to go with it. I essentially did two jobs. There is not a single job for health educator in my area that does not require an RN. I tell you all of this because it drives me nuts that there is now going to be a MCHES. The last thing we need is ANOTHER certification that won't matter unless I am an RN! Why are there those that feel another level would make us more reputable? Until we separate ourselves and can convince health entities that there is a reason to hire us, we can spend all the time/money in the world on useless certifications. I love health education but am not working as a health educator because I have no intention of getting a nursing degree and it saddens and disappoints me. This is the issue we should all be working towards, NOT pushing for more levels of a certification that means absolutely nothing in most parts of the country.

Sooter MPH CHES

This has been a very interesting discussion and I finally wish to put in my two cents. As an unemployed but job seeking Health Educator/Promoter I am always frustrated by seeing a position that I would be perfect for until I see must be license RN, Dietitian etc. I have had my CHES within 6 months of graduating from grad school because I was told that it would make me more valuable to the market place. Which is what all of us need to be. Ms. Harrington has state it most accurately "We need to figure out how to make the intangible tangible before we can expect legislators to listen and appreciate what we do. How can we turn our value into dollars saved? or maybe that is not the correct way of thinking - but how can we quantify our value?" That will make us valuable to those who wish to employ us as a professional.

I feel that my MPH in Health Promotion is a valuable commodity in helping people to shape healthy lifestyles and in understanding why they are doing what they are doing and how to change that cycle. Health Education and Promotion is very close to Health Behavior Sociology because we all are dealing with that aspect of how to change unhealthy behavior to healthy behavior. Our education should include more Psychology, Medical Terminology and A&P (Anatomy/Physiology) to be able to compete with RN's etc.

We need some form of licensure to become legitimized in the eyes of Medical and Business Corporations.

DKerr, PhD, CHES

I have been reading the CHES posts with interest. I always find it interesting that people believe anyone can teach (even a monkey!). I would not pretend to know how to take blood or put in an IV, or God forbid a catheter, so I don't believe nurses should call themselves educators without the accompanying instruction in education theory, learning styles, pedagogy, etc. I don't agree that anyone can present content information...at least in an effective way. The biggest fear in America is still public speaking...and presenting information in a way that keeps an audience interested, attends to different learning styles, and is evidence-based and timely is a challenge. Most of us know that to be effective health educators we must continually update our skills and our content information since health information is constantly changing. I see the role of a health educator as being more specialized than that of a public health professional. That is why there is a CPH and a CHES. !

Also, one is more science-based and the other more education-based. I don't know much about rats causing disease, but I sure know a lot about how to teach comprehensive sexuality education. We have had many nurses in our graduate program that came in thinking that they were already health educators, and leaving knowing that they were mistaken at the onset and after completing our program can now truly claim the title "health educator". Hospitals and other entities requiring nursing degrees for health educators are not educated about the difference or are concerned about liability issues of having non-medical personnel in hospital settings. I agree with Sarah Hallsky (a former student of mine that initiated this discussion) that our roles should be differentiated...and both should be valued! Our focus on primary prevention with educational programming for behavior change is what is truly needed to bring down health care costs, not more medical professionals practicing tertiary prevention or trying to educate people without the educational back ground. A team approach would be best.

TWatson

Well I expected some chatter and a few spats about this, but I am excited to see folks interested in the issue of credentialing. It has been fun to read what you all have written and shared about this issue and wanted to add a few more thoughts. While many of you have opined about CHES and the profession as a whole, I am not sure that my initial questions were answered in many posts (not that it would have been a prerequisite!!)

A summary

Those for It seems that many feel a need to differentiate ourselves from other professions (I did not intend this to be an US/THEM discussion especially with nurses) because we value the unique skills we as a profession have.

Also, it appears that some would like to see a mandatory license of some sort to help differentiate and provide legitimacy.

You know, I was in a sociology of medicine course last semester, and read a great article about the medical profession. In the 1800's many medical professionals were not trained the way we think of them now... in fact most were apprentices and there was significant numbers of medical professionals calling themselves doctors who were simply trying to sell their patent medicines. Truly trained physicians (from England and New England schools of medicine) were frustrated because anyone with some background similar to medicine could call themselves a doctor and practice. Guess what they did? They formed a strong and unified professional organization (the AMA) that advocated for a license in order to practice medicine (including many legislative actions like the 1906 Clean food and drug act)... In order to become licensed, a person would have to attend an accredited school of medicine that was established under the strict curriculum of the day. That in essence limited the pool of potential individuals who could practice and insured continued future control of quality and professional standard (as well as a control of the supply market that would eventually drive up the cost of

medical care and create an elite profession)...

This process legitimized medicine as a profession and managed the profession for the next century. Where did it start? With a small group who wanted to ensure their profession was managed well and provided a quality service. Perhaps we can learn something here. Some have expressed an approach that billing and procedure codes are where our bread may be buttered. Those against... There is some contention that CHES is not helpful nor has it fulfilled its role in setting the profession apart (IE demanding more pay). So... what are we going to do? Remain frustrated? Go back to school for a different degree (nursing perhaps :-)? (FYI... my degrees are all over the board... Health promotion and Education, Public Health (admin emphasis), and Political Science) Pine about this in the biannual merry-go-round?

Or unify, organize, advocate, and construct the unique supply of health professionals that will lead to lower mortality, increase longevity, improve quality of life and lower overall health expenditures.

My motion... Get behind ONE of the many organizations that will likely lead us down this road <http://www.cnheo.org/>. Then let us use CHES, the CUP, the seven competencies of a health educator, some kind of professional accrediting system for preparation, and get a licensing board established. Anyway this makes me sad.... :( I am sorry that the extensive e-mails have caused some to leave... But I really think this is important to talk about in the profession...

Maybe we will just have to have these conversations at Conferences and not during our normal VERY busy ays.

AYeager, MPH

Hi Tyler and all,

I think that these types of discussions are a big reason WHY we have the HEDIR. As a local health department person, we don't always get to attend National conferences. The HEDIR offers a discussion forum for just the kind of things it has over the past few days....resource assistance, feedback, and discussion of topics pertinent to our field. When I don't have time during the day to read through the long ones and they are of interest to me, I save them in a file and go back to them. Matter of fact, I sometimes go back to old discussions from previous years that I knew I would want to refer to/brush back up on from time to time. I think that everyone must decide what is important for them and their work and profession. For those who choose to leave the HEDIR, that is sad because we know what they'll be missing. However, maybe they do not have the same need for these discussions that some of us do that hang around! Some people leave and come back later. I want to encourage us to continue dialogue and discussion about the profession and our needs - daily and long-term. Communication is the key!

WCissell

Tyler, great post. Thanks for getting this discussion rolling. Do not let a noisy unsubscribers rattle you. There will still be more than 1700 subscribers left. They are protesting, otherwise they would have quietly unsubscribed without posting the message to the entire subscribership.

IWong, MSPH

A long time ago, I was part of the debate about certifications for Health Educators. This was sparked by C Everrt Koop and making recognizing Public Health as a "certified" discipline. We started the debate in the late '90s and the CHES certification came about, but many of us disagreed with it. I was also asked in the '90s to write the original standards for a health educator for ACHA Health Promotion Section.

In short, the discussion is not "can a nurse be a health educator", the question is what qualifications does a person need to be a health educator. Just because I have a Masters of Science in Community Health Education does not make me a nurse because I was not trained to be nurse is the same logic why a "nurse" is not a health educator. We still get confused between patient education and health education/health promotion.

I always refer back to the Ottawa Charter for Health Promotion Health Promotion Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. Prerequisites for Health The fundamental conditions and resources for health are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites. Advocate Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioral and biological factors can all favor health or be harmful to it. Health promotion action aims at making these conditions favorable through advocacy for health.

Enable Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men. Mediate The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health promotion strategies and programs should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health Promotion Action Means: Build Healthy Public Policy. Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create Supportive Environments Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility. Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure

positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy. Strengthen Community Actions Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavors and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support. Develop Personal Skills Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health. Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves. Also, to the SOPHE code of ethics.

In my opinion, if you don't do all of the above, you're not doing health education, you're doing patient education.

CBani, Ph.D.

DITTO, Amy (Yeager)!! This is certainly one of the places where this discussion should be taking place.

Tyler - I would argue people are not leaving BECAUSE OF the conversation you initiated. This kind of thing happens ALL the time on EVERY listserv of which I am a part. So, relax. You did not "create the opportunity."

BTW - In BOTH my master's and doctoral programs 1/3 of the enrollees were nurses, a few were doctors. In EVERY health education department at the four universities where I taught at the master's level, 1/3 or more of the enrollees were EITHER nurses or physicians. No matter which way you cut it, there clearly is something definitive and valuable that the health education profession offers medical professionals that does not exist in their respective fields.

Over my 25 years in the profession, I have always been struck most by the "great ease" with which ANYONE from various professions have taken on the title of "health educator" without the requisite training. I am an extremely compassionate, caring and nurturing person. I am an educator by training and avocation, with the great skill of communicating well and effectively with people across various socioeconomic levels and cultural backgrounds. I have a very extensive scientific background and keen knowledge of the human body and associated disease states. And, I can guess, with a fair amount of accuracy, the disease or condition a person may have based on the symptoms they describe or show. Yet, it would never even cross my mind for one minute to call myself "a nurse" or "a doctor" or "a counselor" or "a social worker."

Clearly, we have MANY issues to be resolved in our field, as your discussion has re-ignited, Tyler - but only, once again! None of these issues are new to us or our profession!

JHopla, MHE

I would call myself one of those "Silent Observer/Learner" people that does not post much.

As living just down the hall from the famous "TYLER" I would have to say that the discussion has been very enlightening and educational.

I have a number of students that come into my office asking about the CHES exam and if it will help them in the future.

I answer back YES. I believe that we need to believe in the system and the basis behind the exam. Then do everything that lies in our power to make it work not just for us as professionals but for those we advise and

mentor (The Future).

Way to go Tyler. Proud to see that you are pushing the issue and making what we love to do better.

MPejsach

Why do you think the extensive discussion caused folks to retreat?

The basic problem is this (again):

- We have talked the talk, and have not walked the walk. We may have frustrated many health education professionals because we talk about this ad nauseam.... FOR YEARS... and, yet, there is no concerted effort to bring solutions to the table.

In my humble opinion, I believe our profession is analogous to, in terms of structure, the so-called health care system: there is none!

Unless we, via a professional group (it takes a village.....) which is willing to say to the mighty Nurses Association, for example that, "You're stepping on our toes. Stop it!" we will continue to be the health care step-child, paid less than others providing less than optimal/mediocre behavior changes opportunities for volunteer communities and participants.

Where's the SOPHE or AAHE committee or SIG on "Marketing Health Educators?"

Where is the SOPHE or AAHE committee or SIG on "Protecting Our Turf?"

Where in APHA and ASHA stand/position and support on health educators doing health education Where are the legislative committees for SOPHE or AAHE and what are they doing about Registered Health Educators?

..... And.... why isn't anyone listening to SOPHE, AAHE, the "consortium," when and if they are try to do something about our sorry status? (hint: we don't have an AMA or ANA, or AHA.... we're a group here and there, a group, so who cares they have a few members here an there, there's no CLOUT/VOTES!)

Here's a bold statement (please prove me wrong): I believe our professional organization should've been fighting for us instead of focusing on academics, publishing, and helping folks in academia make tenure via articles and positions on their boards. While scholastic contributions are important, the short term and long term results do not add up to anything in terms of better salaries, better positions, reimbursement and growth of the profession! We get smarter.... but poorer.

Again, it's deja vu all over again, with the same comfortable "health educators" complaining that we are complaining too much. The same comfortable "health educators" complain that shaking up the current status quo (the same as it was 30 years ago) will do more harm than good. SHOW ME THE DATA. The same comfortable "health educators" complain, that "We should be talking about other more important issues, like policy and unemployment!" Well, we are actually talking about unemployment and policy.... regarding our profession.

VBooth

Having enjoyed this conversation VERY much, heres my \$.02, I am a school health educator (7yrs), undergrad and grad studies all in Health Education. I am one of those "all health education" rarities, (who has a job) soon to be dinosaurs I suppose. I am also an expired CHES. I felt the CHES test was comprehensive and was proud to have the credential, however once hired as a school health teacher I found the continuing education requirement for CHES to be too costly to maintain in addition to my district's requirements. Seems like it also became unnecessary for my current position in a school (dont believe admin knows what it is). I know that if I aspire to teach elsewhere maybe the credential will help that pursuit. I think I will remain expired for now, am I missing something?

CCarrio

Gsooter, I think that if people's lives are so busy that they can't hit the delete button, then these people need to become either 1. better organized or 2. get a better more relaxed life.

I don't wish to miss the discussions, those that I am not interested in following are just deleted from my inbox. I receive over a hundred emails a day some are important some are just plain garbage and it takes less time if you designate a special time to go through emails than to try and keep up during the day. If you are afraid of missing an ultra important email you can set up a warning or heads up for the incoming email.

Sorry if this offends but that is how I feel when I see people wanting to quit HEDIR after a discussion that elicits good response from those that are passionate about their jobs.

Jpinilla MPH

I have thoroughly enjoyed all of your emails! I just received my MPH in December, and because of these emails I have learned a lot about the history and difficulties of our profession. Since I am just now beginning my career, I appreciate the insight of those who have come before me. I hope that this conversation continues, and that others just as intriguing will pop up.

The HEDIR for Health Educators – Discuss, Debate, Question, Contribute...

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