Social Work in Health Care
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wshc20

Health Education for Social Workers: A Primer

Daphne C. Watkins PhD [a] & Jennifer A. Hartfield MPHPhD(c)MCHES [b]
[a] School of Social Work, University of Michigan, Ann Arbor, Michigan, USA
[b] School of Public Health, University of Michigan, Ann Arbor, Michigan, USA

Version of record first published: 11 Sep 2012.

To cite this article: Daphne C. Watkins PhD & Jennifer A. Hartfield MPHPhD(c)MCHES (2012): Health Education for Social Workers: A Primer, Social Work in Health Care, 51:8, 680-694

To link to this article: http://dx.doi.org/10.1080/00981389.2012.686474

Social Work in Health Care, 51:680–694, 2012

ISSN: 0098-1389 print/1541-034X online
DOI: 10.1080/00981389.2012.686474

Routledge
Taylor & Francis Group

Health Education for Social Workers: A Primer

DAPHNE C. WATKINS, PhD
School of Social Work, University of Michigan, Ann Arbor, Michigan, USA

JENNIFER A. HARTFIELD, MPH, PhD(c), MCHES
School of Public Health, University of Michigan, Ann Arbor, Michigan, USA

Health education, as a discipline and specialization, is often overshadowed by other branches of public health (e.g., bio-statistics, epidemiology, and policy management). Although social workers have been performing health education for decades, social work students may not know the history of health education as a practice profession and its uses in a social work context. The purpose of this article is to introduce the field of health education to social work students who are currently, or anticipate, practicing health education in their careers. We conclude with implications for social work education and a discussion about the impact of collaborative social work and health education efforts in the reduction of health disparities.

KEYWORDS collaboration, health care, health education, prevention, social work training

Dating back to the early twentieth century, social workers have been actively involved in public health (Ruth et al., 2008). Social work and public health share a historical social justice mission aimed at decreasing health disparities, enhancing well-being, and ameliorating social health problems among the most vulnerable populations (Marshall et al., 2011). Like health educators, the roles of social workers are vast and they provide services ranging from health and mental health care, to substance abuse treatment (Bureau of Labor Statistics, 2010b). Due to their shared commitments and commonalities, the independent roles of health educators and social workers are

Received November 10, 2011; accepted April 13, 2012.

Address correspondence to Daphne C. Watkins, PhD, University of Michigan, School of Social Work, 1080 South University Avenue, Ann Arbor, MI 48109. E-mail: daphnew@umich.edu.

often blurred. Social workers provide a range of programs and services across the lifespan, which allows for the creation of tailored treatment plans (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larson, 2009; Reamer, 2006) and continuums of care (Gehlert & Browne, 2006). Their roles in the continuum of care transpire through their work in a variety of settings including public health and health care systems and among those seeking health care. The majority of urgent health and crisis interventions, mental health care, and psychological services in the United States are provided by social workers (Block, 2006; Bureau of Labor Statistics Occupational Handbook, 2010b). Yet, health education competencies are often excluded from the public health content delivered to social work students. This article serves as a primer for social work students and trainees who are interested in implementing health education in their social work careers.

Social work services can range from psycho-education and counseling services to providing patient referrals and discharge assistance. These services are usually provided in conjunction with a patient care team where the social worker acts as the service coordinator. Within the patient care team, the social work values of autonomy, cultural awareness, and cultural competency (Hepworth et al., 2009) become useful as patients and their families cope with changes in health status and subsequent psychological, social, and economic implications. During such cases, the focus of social work services becomes one of secondary and tertiary stages of maintenance, which is different from the primary focus on prevention. Primary prevention, though vital to practicing social workers, is largely aligned with the mission of health education, and is an essential part of the health and well-being of individuals and communities (Bensley & Brookins-Fisher, 2003; McDermott, 2008; Simons-Morton, Greene, & Gottlieb, 1995).

The fields of social work and public health must be acknowledged as two closely aligned disciplines that borrow frameworks and ideologies from each other (Ruth et al., 2008). This idea has many health and human service professionals postulating that the functions, responsibilities, and approaches of the fields are so parallel that the responsibilities of health educators can be easily subsumed under those of social workers (Ruth et al., 2008, Marshall et al., 2011, Schild & Sable, 2006; Gant, Benn, Gioia, & Seabury, 2009). Although there are a large number of the social work professionals who engage in health education, we caution against this sweeping generalization. There are identifiable differences between the roles of social workers and health educators that cannot be ignored but warrant further exploration. For example, we recognize that social workers apply a preventive focus to casework and use informal risk analysis to promote early intervention, but traditionally, the majority of their work is to mitigate health problems after they have risen and are largely concentrated in secondary and tertiary prevention. (Marshall et al., 2008). With respect to the interdisciplinary efforts to expand social work responsibilities toward improving health and preventing

disease—and although areas of public health are often acknowledged in social work education programs—social work training tends to be limited with respect to specific health education content. To account for this, social work education has encouraged all social workers, regardless of their specialty or concentration, to have familiarity with health education, prevention, and advocacy knowledge and skills (Block, 2006; Gehlert & Browne, 2006). However, social workers interested in primary prevention, a principal aim of health education, are encouraged to acknowledge the unique contributions of health education to patient well-being and assess how the responsibilities and competencies of health education can be used to complement those of social workers. Depending on the task, social workers will need to determine if they are equipped to perform the duties themselves, or if they should elicit the help of a certified health educator to address their patients' needs.

The purpose of this article is to introduce the field of health education to students who are currently, or anticipate engaging in social work research and practice with a health education focus. We begin by describing the core values of social work through a health education framework. Next, we discuss health education as a discipline, distinguish it from public health, and outline the values and standards of health education compared to social work. We then present terminology from the disciplines and briefly outline training, credentialing, and knowledge acquisition for health educators as well as social workers interested in public health. Finally, we discuss implications for social work education and the importance of collaboration between social workers and health educators in eliminating health disparities.

THE CORE VALUES OF SOCIAL WORK THROUGH A HEALTH EDUCATION LENS

Social work is a growing specialty that provides psychosocial support to clients and their families who have experienced illness, injury, and disease and may need support adjusting to changes in health status (Bureau of Labor Statistics, 2010b). We understand that the field of social work is varied in terms of the types of clients who benefit from social work services. Therefore, for the purposes of this article, the term "social worker" will be used to refer to social work professionals in clinical, medical, and/or public health-focused settings or who have had social work training with a health concentration. Social work in health care is defined broadly as "the professional continuum of services designed to help individuals, groups, and families improve or maintain optimal functioning in relation to their health" (*Certified Social Worker in Health Care Information Booklet*, 2010, p. 1). Social workers with certification in health care settings provide leadership in their health care organizations through the development of new resources,

services, and programs to meet patient needs. In addition, public health and health care social workers use their knowledge and experiences to develop standards of practice, recommend health policy, improve health programs, and ensure patients, families, and organizations receive high quality and state of the art social work services. The core functions of public health and health care social workers include psychological assessment, resource management, and continuity of care planning, psychosocial interventions, crisis intervention, health education, and interdisciplinary collaboration (*Certified Social Worker in Health Care Information Booklet,* 2010).

HEALTH EDUCATION AS A DISCIPLINE: HISTORY, VALUE, AND BRANDING

The World Health Organization (WHO) defines *public health* as "a social and political concept aimed at improving health, prolonging life, and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention (1998, p. 3). Public health should not be confused with *health education*, which "comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual an community health" (WHO, 1998, p. 4). Health education is one of the many branches of public health and includes instructional activities and other strategies to improve individual health behaviors, as well as the development of organizational efforts, policy directives, economic supports, environmental activities, mass media, and community-level programs. Compared to the other branches of public health, health education is the only one principally aligned with the core knowledge and skills that involve the behavioral or social sciences (Woodhouse et al., 2010). According to Green and Kreuter (1999), health education "aims at the voluntary actions people can take on their own part (individually or collectively) for their own health or the health of others and the common good of the community" (p. 19). Not to be confused with health education, *health promotion* encompasses health education and "aims at the complementary social and political actions that will facilitate the necessary organizational, economic, and other environmental supports for the conversion of individual actions into health enhancements and quality of life gains" (1999, p. 19). Health education is more effective when it is supported by structural measures (i.e., legal, environmental) and when the people most affected by it are involved. Health education settings provide channels for delivering programs, accessing specific populations and gatekeepers, examining existing communication systems for diffusion of programs, and facilitating the development of policies and organizational change to support positive health practices (Stellefson, Barry,

Chaney, Chaney, & Hanik, 2011). Primary health education settings include communities, worksites, consumer markets, health care sites, and schools where universal health determinants such as race, culture, gender, age, and/or socioeconomic status are identifiable.

The U.S. Department of Commerce and Labor formally recognized "health education" as an occupation for the first time in 1998. However, the span of health education research and practice by public health professionals has made a noteworthy impact on underserved populations for almost half a century (Woodhouse et al., 2010). During the 1960s and 1970s health education changed single, health-directed acts (i.e., obtaining immunizations) into community-wide, public health initiatives and changed medical care behaviors through patient education and self-care initiatives (Glanz, Rimer, & Lewis, 2002). However, public health officials were not confident that the field could keep up with radically changing public health targets. The increasing awareness of health disparities because of social circumstances prompted questions concerning the mass distribution of health education and issues of equity and social justice in the 1980s. Nineteenth- and twentieth-century public health and health education initiatives succeeded in reducing the impact of communicable diseases, increasing the knowledge of complex targets and social circumstances that spanned the life course (Green & Kreuter, 1999).

Despite the long-term and documented success of health education, the achievements have not come without their challenges. The branding of health education as a discipline has been an uphill battle for health education professionals for decades. In fact, Stellefson and colleagues (2011) posit that there is misunderstanding regarding the role of the health educator both inside and outside the field. Certainly, the distinction that health education has from public health has been one of the primary areas of confusion, as overlap exists between 79 health education sub-competencies and 68 public health competencies. The remaining 42 and 44 sub-competencies and competencies were found to be unique to health education and public health, respectively (Bartee, Olsen, & Winnail, 2006). Yet, Bartee and colleagues suggested that health education professionals would be in higher demand if they did more to market their uniqueness and ability to contribute to the field of public health. Here, we advise the social work student to have a clear understanding of health education by providing a distinction between it and other health service professionals where the day-to-day responsibilities may overlap, such as the responsibilities of social workers in health care.

Health education and social work also share commonalities with regard to training, professional ethics, and impact. For example, like health educators, social workers are trained to use theoretical approaches to implement psychosocial and behavioral change in their research and practice. Similarly, both are trained to use evidence-based approaches in their distribution of

services (Brownson, Fielding, & Maylahn, 2009; Gambrill, 2003). Across both professions, theoretical approaches and evidence-based research and practice are tailored to the unique needs of the client, not reflecting the "one-size fits all" approach. Health educators, like social workers, tend to be familiar with the community in which they serve and are knowledgeable about various aspects of the community when opportunities present themselves to promote healthy living for their clients (Bensley & Brookins-Fisher, 2003). Due to the similarities across disciplines, health educators and social workers also share much of the same professional jargon in their daily work. In the next section, we discuss three key terms that can create uncertainty for students and trainees who may be trying to distinguish between social work and health education.

CREDENTIALING, PRACTICE, AND INTERVENTION: SIMILAR BUT NOT THE SAME

One of the key indicators of success in both social work and health education is demonstrated competency by professionals. There are a number of professional terms used by both social workers and health educators; however, due to space limitations, we focus our discussion on three: credentialing, practice, and intervention. An understanding of the operational and contextual definitions for these terms will help the social worker who is interested in health education research and practice understand the similarities and differences in their use by both professions. Moreover, we pause to acknowledge that the meanings of these terms for each discipline are closely related, yet they are not the same.

Credentialing

Professional credentialing in any discipline is a demonstration and professional acknowledgment of competency in content and practice. It signifies additional training and that continued education has and will be achieved leaning to mastery of the field. According to the *Competency-Based Framework for Health Education Specialists*, credentialing is "an umbrella term referring to the various means employed to designate that individuals or organizations have met or exceeded established standards" (2010, p. 80). Health education is a population-based profession and therefore has distinct competencies from clinically based professions (Livingood & Auld, 2001). As the first population-based profession to develop competencies, health educators have identified research and practice standards for accreditation, certification, and other quality assurance systems for more than 20 years (Birkhead, Davies, Miner, Lemmings, & Koo, 2008).

Like social work, health education is a branch of public health that maintains its own professional credentialing, standards and ethics, and networking associations (e.g., the Society for Public Health Education and the American Association for Health Education). In order to be a "certified" health educator, individuals must undergo additional certification training and assessment. The National Commission for Health Education Credentialing, Incorporated (NCHEC; 2010a) outlines responsibilities and competencies and administers a Certified Health Education Specialist (CHES) exam for individuals who desire to demonstrate evidence of their knowledge of the seven areas of responsibility and competency for health educators. The CHES exam includes a comprehensive set of competencies and subcompetencies defining the role of the health education specialist. These seven key areas are projected to be relevant to any health educator regardless of where individuals received their formal training (http://nchec.org). After passing the CHES exam, individuals are awarded CHES credentialing, a licensure number, and may include this certification along with their academic degrees as evidence of professional competency in health education. More recently, a Master Certified Health Education Specialist (MCHES) has been employed to allow health educators to demonstrate advanced proficiency with the seven health education responsibilities and competencies.

Health education credentialing and certification was designed to work in a similar manner as professional licensure for social workers. However, some would argue that efforts to adopt and promote health education certification have been unsuccessful and have resulted in major barriers for health education as a profession (Cioffi, Lichtveld, Thielen, & Miner, 2003; McDermott, 2008; Stellefson et al., 2011). A report commissioned by the leading public health education organizations in the nation found that the awareness of CHES certification was associated with a greater understanding of health education by employers. However, CHES certification was neither appreciated by employers nor did it carry as much recognition with employers as it should (Hezel Associates, 2007). Establishing a need for certified health education specialists is contingent upon professional credentialing in health education, just as it is in social work. Unlike the universal acceptance of social work licensure; though, the manner in which CHES is valued among employers varies greatly from agency to agency.

The *National Association of Social Workers* (*NASW) Code of Ethics* (2005) outlines the responsibilities and competencies required by social workers, such as having and continuing to develop specialized knowledge and understanding about the history, traditions, values, family systems, and expressions of the major client groups to which they provide services. Compared to health educators, social workers have more certification concentrations and specialty options. In fact, the range of credentialing and specialty options available to social workers is as varied as that for nursing professionals or physicians. Several different certifications exist, and

are maintained and guided by the National Association of Social Workers (NASW). Examining the varying degrees and certifications are beyond the scope of this article; however, readers are encouraged to visit the NASW website for details (http://www.naswdc.org).

Practice

The term "practice" is frequently used in both health education and social work settings; yet, the term has slightly different meanings for each field. Social work practice often involves client services such as counseling, crisis intervention, along with other duties like community organizing, program evaluation, social welfare policy analysis, teaching, social advocacy, and case management among others. Health education practice may include many of these functions with the exception of counseling and case management. Counseling and case managements are two aspects of social work that are truly germane to the field as interpersonal practice is a concentration area that is popular in social work and non-existent in health education. Social work practice involves developing solutions to problems by using the strengths of the community and incorporating the culture of the individuals and families of interest. Effective social work practice can mean working to ensure client well-being and building partnerships with those involved in strengthening community capacity and resolving issues.

Health education practice is akin to that of social work in many ways, and can be best described in terms of its major responsibilities and functions, which include planning, implementing, and evaluating programs to promote healthy living and prevent disease among individuals and communities (Aday, 2001; Bensley & Brookins-Fisher, 2003; Livingood & Auld, 2001; Simons-Morton et al., 1995; Woodhouse et al., 2010). Despite its focus on the health of the public, health education practice is not limited to population-level interventions. Health education can be applied at the individual, organizational, community, and governmental level. A multilevel practice approach may be employed by both disciplines to address complex issues as each level provides opportunities for health educators and social workers to mobilize communities and advocate for sustainable change. Like social workers, health educators collaborate with diverse health, medical, and social service professionals to improve quality of life. However, health education practice does not include counseling or therapy sessions and compared to practicing social workers, the likelihood of health educators opening a private practice is rare.

Intervention

Intervention is a term commonly used in the research and practice settings of health educators and social workers. Among social workers, intervention

and treatment plans are steps identified from collaboration with the client and other members of the patient care team to achieve objectives identified during the initial assessments. In response to critical incidents that are both global and national, training for health care social workers involves providing treatment interventions for their clients (Coulter & Hancock, 1989; Schild & Sable, 2006). Methods of provision could include any combination of client, family, and community modalities, the involvement of significant others, the negotiation of community resources, and acquisition of support services to address clients' needs. For health educators, interventions are strategies and activities designed to promote behavioral changes while addressing determinants of health. These behavioral interventions may be at the individual, community, organizational, and/or governmental level. Political advocacy, media campaigns, and one-time events (e.g., health fairs and diabetes screenings) are examples of common health education interventions. Due to the focus on behavior change, there is also a social marketing aspect of health education interventions that may not be present in traditional social work interventions. Oftentimes, health educators must engage in a number of artistic and imaginative activities to design health communication messages and mediums for their clients. By messages, we are referring to communication aspects such as appeal (e.g., positive emotional appeal, humorous appeal, threat, or fear appeal) and language tone (casual, formal, persuasive, affirmative, etc). On the other hand, mediums are the communication intervention materials that are most preferred (e.g., flyers, brochures, Web-content, videos, radio spots, billboards, workshops, and seminars).

HEALTH EDUCATION BY SOCIAL WORKERS: SHOULD YOU DO IT ALONE OR COLLABORATE?

In the 1990s, government and private sources mandated collaborative approaches in the human services to reduce duplication and promote coordinated service provision (Abramson, 2002). More recent studies posit that health education significantly improves population health if its professionals collaborate with other health professionals and enlists multiple stakeholders to help address their problems (Tyus, Freeman, & Gibbons, 2006; Valencia, Kingston, Nakamura, Rosenfield, & Schwartz, 2004). These studies assert that health educators who collaborate with social workers and use interdisciplinary approaches will reveal multiple competencies, skills, and experiences to tackle the challenging public health issues of their communities. Professionals who implement interdisciplinary approaches with a common purpose share an integration of various professional perspectives in the decision-making process and communicate their roles based on education, skills, and expertise (Abramson, 2002). A primary aim of increased

collaborations between health educators and social workers is for different professionals to arrive at a consensus that leads to improvements in the continuum of care. Providing a continuum of care that reduces the duplication of services and enhances the strengths of social work and health education can lead to organizational efficiency and effectiveness, resource sharing, and treatment costs reductions.

Health professionals have a long history of collaborating; yet, the new wave of collaborative efforts have focused on eliminating health disparities and emphasizes the modernization of health services, particularly for underserved populations. An example of this is the long-standing collaboration between doctors and nurses, who have always worked closely together. More recently, time and financial constraints of the patient-care model (Bodenheimer, 2007) have made health care collaboration more difficult (Lindeke & Sieckert, 2005). The collaboration between social workers and health educators is no different. Taking advantage of the opportunity to learn how social workers and health educators can use their unique perspectives to address health disparities will dispel the belief that interprofessional collaboration is fragmented and transient (Reeves & Lewin, 2004; Thomas, Sexton & Helmreich, 2003). Rather, collaborations between the two acknowledge the unique skill sets that discriminates health educators and social workers from other health care professionals. Differences between social work and public health do not exclude collaboration and requires employing a multidisciplinary approach to address complex public health and sociocultural issues. Currently, many social workers and health educators collaborate on patient care to improve patient outcomes. Each discipline presents a unique approach to addressing pertinent public health issues individually, but collectively a more comprehensive approach is needed (Bediako & Griffith, 2007; Coulter & Hancock, 1989; Ruth et al., 2008).

The ways in which health educators and social workers can contribute to the elimination of health disparities are countless. Both are trained to collect and analyze data and identify community needs prior to planning, implementing, monitoring, and interpreting programs designed to encourage healthy behaviors. A growing literature has demonstrated the importance of interprofessional collaborations among health educators and social workers (Holtrop & Jordan, 2010; Stellefson et al., 2011). For example, Stellefson and colleagues acknowledge the overlapping marketing interests of social workers and health educators—among other health professionals—as well as the competition for each profession's allotment of jobs and available resources. Likewise, Holtrop and Jordan (2010) proposed a patient-centered medical home (PCMH) model that includes a team of nurses, dieticians, pharmacists, health educators, and social workers who provide comprehensive primary care for children, youth, and adults. Effective collaboration will result in an expansive reach of its intended recipients, positive health behavior changes, and the overall reduction of health disparities (Bediako & Griffith, 2007).

Apart from the unique contribution of the social worker and the health educator, the knowledge and experiences of both account for their utility in efforts toward the reduction of health disparities and has important implications for professional training and career development.

A more recent and popular specialty of education, credentialing, and practice in social work is that of the "public health social worker" (Bureau of Labor Statistics, 2010a, 2010b; Schild & Sable, 2006) whose role involves incorporating public health into social work settings. Public health social workers provide services across the continuum of care and in numerous settings and sometimes have a special certification in health care, such as the Certified-Social Worker in Health Care (C-SWHC). Eligible applicants must also agree to adhere to the *NASW Code of Ethics* and the *NASW Standards for Social Work in Health Care Settings*. Although public health social workers may demonstrate competent research and practice in both social work and public health, rarely are the responsibilities and competencies of both disciplines the focus of course content and training opportunities. Certainly, for a social worker to obtain the competency to perform the duties of a health educator, he or she would need to immerse him/herself into the field of health education because a meager introduction or surface-level exposure to the content would not suffice. Conversely, the same could be true for a health educator who aspired to engage in social work research and practice. To satisfy career interests and their desires to engage in primary, secondary, and tertiary stages of care, some students have opted to pursue dual degrees and concentrations. During these programs, students may be assigned to field placements that focus on primary prevention and allow them to engage in health education practice.

IMPLICATIONS FOR SOCIAL WORK EDUCATION

Health education is not limited to the field of public health, but it is most noted in public health. Studies have reported career outcomes for dual MSW/MPH programs compared to MSW programs with a health concentration and students' abilities to perform both social work and public health duties (Ruth, Wyatt, Chiasson, Geron, & Bachman, 2006; Ruth et al., 2008). Currently, there is little evidence to support the notion that a dual MSW/MPH degree will result in the likelihood of job obtainment and increased job security. Likewise, no statistical significance in career satisfaction and pay has been found between the dual degree group and MSW-only group (Ruth et al., 2006). On average, the dual degree graduates were employed in similar settings and performed similar roles as the MSW-only group. The dual degree group also expressed challenges with having both degrees. For example, self-identification was an issue as several referred to themselves as a "social worker" when probed, while others referred to themselves as both

a "social worker and public health practitioner" (Ruth et al., 2006). Future social work education efforts geared toward the integration of social work and supplemental health care disciplines would benefit from more studies that explore the professional competencies and short- and long-term career outcomes of students who obtain dual MSW/MPH degrees as opposed to those who obtain an MSW degree with a health concentration.

Depending on the short- and long-term career goals of social work students, specific areas of social work and public health training may be required. For example, social work students interested in social work and public health as a career might pursue dual master's degrees in social work and public health (MSW/MPH). Others may pursue an MSW degree with a concentration in health. However, it is important to note that the distinction between social work programs with a concentration in health and a dual MSW/MPH program is one of quality, depth, and focus in terms of the health content that is covered (McClelland, 1985). For example, social work students with health concentrations may not receive formal training in health education content and similarly, MSW/MPH programs may be structured in a way where courses completed in one degree fulfill requirements for the second (Schild & Sable, 2006). Such academic programs may be limited in the amount of health education content that is covered and the number of hours spent engaging in "true" health education research and practice. Therefore, social work students who hold an interest in health education should consider pursuing additional health education courses and opportunities where they can fully engage in work that exemplifies that of the health education responsibilities and competencies.

CONCLUSION

The fields of health education and social work are closely aligned, which can make it challenging to delineate the roles and responsibilities of each field (Ruth et al., 2006). Both are concerned with physical, emotional, and environmental factors that affect well-being. Despite these similarities, however, the two are very distinct. Social work is primarily concerned with assisting people in their daily lives, solving personal and family problems, and health issues. Health education involves health promotion activities and strategies rooted in behavioral theories that seek to foster healthy behaviors. Addressing health problems, mobilizing communities, and advocating for policy change are examples of areas where the two share commonalities. Social work students who are seeking to expand their studies to include health education can expect to benefit from strengthening their professional identity (Coulter & Hancock, 1989; Schild & Sable, 2006) and incorporating a well-balanced micro-, meso-, and macro-perspective into their careers.

REFERENCES

Abramson, J.S. (2002). Interdisciplinary team practice. In G. Greene & A. Roberts (eds.), *Social Work Desk Reference* (pp. 44–50). New York, NY: Oxford University Press.

Aday, L.A. (2001). *At Risk in America: The Health and Health Care Needs of Vulnerable Populations in the United States* (2nd edition). San Francisco, CA: Jossey-Bass.

Bartee, R.T., Olsen, S.E., & Winnail, S.D. (2006). Comparison of health education and basic public health professional competencies. *American Journal of Health Studies*, *21*, 11–19.

Bediako, S., & Griffith, D.M. (2007). Eliminating racial/ethnic health disparities: Reconsidering comparative approaches. *Journal of Health Disparities*, *2*(1), 49–62.

Bensley, R.J., & Brookins-Fisher, J. (2003). *Community Health Education Methods: A Practice Guide* (2nd edition). Sudbury, MA: Jones and Bartlett Publishers, Inc.

Birkhead, G.S., Davies, J., Miner, K., Lemmings, J., & Koo, D. (2008). Developing competencies for applied epidemiology: From process to product. *Public Health Reports*, *1*(supplement 1), 67–123.

Block, P. (2006). Alternative, complementary, and integrative medicine in a conventional setting. In S. Gehlert & T. A. Browne (eds.), *Handbook of Health Social Work* (pp. 673–707). Hoboken, NJ: John Wiley and Sons.

Bodenheimer, T. (2007). Coordinating care: A major (unreimbursed) task of primary care. *Annals of Internal Medicine*, *147*, 730–731.

Brownson, R.C., Fielding, J.E., & Maylahn, C.M. (2009). Evidence-based public health: A fundamental concept for public health practice. *Annual Review of Public Health*, *30*, 175–201.

Certified Social Worker in Health Care Information Booklet. Retrieved from http://www.naswdc.org/credentials/applications/s-swhc.pdf

Cioffi, J.P., Lichtveld, M.Y., Thielen, L., & Miner, K. (2003). Credentialing the public health workforce: An idea whose time has come. *Journal of Public Health Management and Practice*, *9*(6), 451–458.

Coulter, M.L., & Hancock, T. (1989). Integrating social work and public health education: A clinical model. *Health and Social Work*, *14*(3), 157–164.

Gambrill, E. (2003). Evidence-based practice: Sea change or the emperor's new clothes? *Journal of Social Work Education*, *39*, 3–23.

Gant, L., Benn, R., Gioia, D., & Seabury, B. (2009). Incorporating integrative health services in social work health education. *Journal of Social Work Education*, *45*, 407–425.

Gehlert, S., & Browne, T. A. (eds.). (2006). *The Handbook of Health Social Work*. Hoboken, NJ: John Wiley and Sons.

Glanz, K., Rimer, B.K., & Lewis F.M. (2002). *Health behavior and health education: theory, research, and practice* (3rd edition). San Francisco, CA: Jossey-Bass.

Green, L.W., & Kreuter, M.W. (1999). *Health Promotion Planning: An Educational and Ecological Approach* (3rd edition). Mountain View, CA: McGraw-Hill.

Hepworth, D.H., Rooney, R.H., Rooney, G.D., Strom-Gottfried, K., & Larson, J. (2009). *Direct Social Work Practice: Theory and Skills*. Belmont, CA: Brooks/Cole Cengage Learning.

Hezel Associates. (2007, July). *Marketing the Health Education Profession: Knowledge, Attitudes and Hiring Practices of Employers*. A study commissioned by the Coalition of National Health Education Organizations, American Association for Health Education, National Commission for Health Education Credentialing, Society for Public Health Education, American College Health Association, and Eta Sigma Gamma. Information available from www.cnheo.org

Holtrop, J.S., & Jordan, T.R. (2010). The patient-centered medical home and why it matters to health educators. *Health Promotion Practice*, *11*(5), 622–628.

Lindeke, L., & Sieckert, A.M. (2005). Nurse-physician workplace collaboration. *OJIN: Online Journal of Issues in Nursing, 10*(1), Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume102005/No1Jan05/tpc26_416011.aspx

Livingood, W.C., & Auld, M.E. (2001). Lessons learned from health education certification. *Journal of Public Health Management and Practice*, *7*(4), 38–45.

McClelland, R. (1985). Joint degrees: Do they strengthen or weaken the profession? *Journal of Social Work Education*, *21*(1), 230–234.

McDermott, R.J. (2008). If health education had vital signs, then where would we take its pulse? *The Health Educator*, *40*, 3–9.

Marshall, J.W., Ruth, B.J., Sisco, S. Ruth, B.J., Bethke, C., Piper, T.M., Cohen, M., & Bachman, S.S. (2011). Social work interest in prevention: A content analysis of the professional literature. *Social Work*, *56*(3), 201–211.

National Commission for Health Education Credentialing, Incorporated. (2010a). *Competency-Based Framework for Health Education Specialists*. Whitehall, PA: American Association for Health Education.

National Commission for Health Education Credentialing, Incorporated (2010b). *Health Education Credentialing*. Retrieved from http://nchec.org/credentialing/credential/.

National Association of Social Workers. (2005). *NASW Standards for Social Work in Health Care Settings*. Washington, DC: NASW Press.

Reamer, F.G. (2006). *Social Work Values and Ethics*. New York, NY: Columbia University Press.

Reeves, S., & Lewin, S. (2004). Interprofessional collaboration in the hospital: Strategies and meanings. *Journal of Health Service Research and Policy*, *9*(4), 218–225.

Ruth, B.J., Sisco, S., Wyatt, J., Bethke, C., Bachman, S. S., & Piper, T.M. (2008). Public health and social work: Training dual professions for the contemporary workplace. *Public Health Reports*, *2*(123), 71–77.

Ruth, B.J., Wyatt, J., Chiasson, E., Geron, S.M., & Bachman, S. (2006). Social work and public health: Comparing graduates from a dual degree program. *Journal of Social Work Education*, *42*(2), 429–439.

Schild, D.R., & Sable, M.R. (2006). Public health and social work. In S. Gehlert & T. A. Browne (eds.), *Handbook of Health Social Work* (pp. 70–122). Hoboken, NJ: John Wiley and Sons.

Simons-Morton, B.G., Greene, W.H., & Gottlieb, N.H. (1995). *Introduction to Health Education and Health Promotion* (2nd edition). Prospect Heights, IL: Waveland Press.

Stellefson, M., Barry, A., Chaney, B.H., Chaney, J.D., & Hanik, B. (2011). Establishing cause for developing and implementing a broad-based marketing effort for the health education field. *Health Promotion Practice*, *12*(23), 379–387.

Thomas, E.J., Sexton, J.B., & Helmreich, R.L. (2003). Discrepant attitudes about teamwork among critical care nurses and physicians. *Critical Care Medicine*, *31*(3), 956–959.

Tyus, N.C., Freeman, R.J., & Gibbons, M.C. (2006). Development of a replicable process for translating science into practical health education messages. *Journal of National Medical Association*, *98*(9), 1505–1509.

Woodhouse, L.D., Auld, M.E., Miner, K., Alley, K.B., Lysoby, L., & Livingood, W.C. (2010). Crosswalking public health and health education competencies: Implications for professional preparation and practice. *Journal of Public Health Management and Practice*, *16*(3), E20–E28.

U.S. Department of Labor. Bureau of Labor Statistics. (2010a). *Occupational Outlook Handbook, 2010–11 Edition*, Health Educators. Retrieved from http://www.bls.gov/oco/ocos063.htm

U.S. Department of Labor. Bureau of Labor Statistics. (2010b). *Occupational Outlook Handbook, 2010–11 Edition*, Social Workers. Retrieved from http://www.bls.gov/oco/ocos060.htm

Valencia, M.A., Kingston, N., Nakamura, R.B., Rosenfield, F., & Schwartz, M.L. (2004). The evolution of health education: The Kaiser Permanente Southern California experience. *Health Promotion Practice*, *5*(1), 20–17.

World Health Organization. (1998). Health promotion glossary, Geneva. Retrieved from http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf