

## The Health Educator's Role in Rural Community Transformation Work: A Multiple Case Study

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### Abstract

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Rural communities in the United States see higher rates of chronic disease and are faced with unique challenges related to their environment. Increasingly activities to address chronic disease are focused on community transformation aimed at the complex interaction between individuals, communities, and environments in a socio ecological approach to health education. Some rural local health departments have received funding for community transformation work (CTW), but it was unclear how implementation was occurring and who at the Local Health Department (LHD) was leading implementation efforts. This study utilized a qualitative exploratory multiple case study approach to understand the role the health educator in community transformation work in rural Illinois. It was found that health educators are leading CTW at rural LHDs. CTW is a shift from the traditional individual based health education work these practitioners have done in the past, but falls in line with the seven areas of responsibilities. Not all the health educators felt ready or prepared to do this work. The issue of resources, specifically funding to support staff time, continues to be an issue. Without sustained funding the start and stop, nature of the health educator's work may continue and it may undermine efforts to reduce chronic disease.

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### 1. Introduction And Background

According to the Centers for Disease Control and Prevention (CDC), chronic diseases—such as heart disease, stroke, cancer, diabetes, and arthritis—are among the most common, costly, and preventable of all health problems in the U.S. (CDC, 2012). Rural communities have seen even higher rates of chronic disease and are faced with unique challenges related to their environment (Gamm, Hutchison, Bellamy, & Dabney, 2002). The physical arrangement of the rural environment is more spread out and often isolated, making access to services and healthy living options difficult. In addition, rural communities are faced with an aging population, lower socioeconomic status, and higher concentrations of ethnic and racial minorities, which puts them at risk for negative health outcomes (Crosby, Wendel, Vanderpool, & Casey, 2012).

With decades of research, public health has made strides in developing interventions to reduce chronic disease by changing social, economic, and cultural landscapes, yet the problems still persist (Rivera & Birnbaum, 2010). Increasingly, activities to address chronic disease are focused on the complex interaction between individuals, communities, and environments in a social-ecological approach to health education (McLeroy, Bibeau, Steckler, & Glanz, 1988; Stokols, 1992; Stokols, 1996). Social-ecological approaches recognize that risk factors such as lack of physical activity, poor diet, alcohol abuse, and tobacco use that contribute to the development of chronic diseases are outcomes of a complex social system (Flaman, Plotnikoff, Nykiforuk, & Raine, 2011; Rivera & Birnbaum, 2010). Social-ecological models have long been recommended to guide public health practice (McLeroy, et al., 1988).

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The passage of the Patient Protection and Affordable Care Act (ACA) increased the emphasis on prevention and led to the development of the National Prevention Strategy (NPS) and subsequent national prevention funding for community transformation at the local and state level (National Prevention Council, 2012). National strategies such as the NPS call for an increased recognition of the advantages of using policy, systems, and environmental approach (PSE) in conjunction with individual-based strategies in efforts to improve community health and individual outcomes; evidence shows that individual-based strategies alone have not succeeded in decreasing the burden of chronic disease (Fielding, 2013). Community transformation work (CTW) is defined as implementing strategies that modify the environment to make healthy choices practical and available to all community members through PSE changes.

Creating infrastructures to make the healthy choices possible is likely to make significant difference in health outcomes in rural areas (Barnidge, et al., 2013). However, much of the evidence to date on environmental and policy change related to physical activity and healthy eating comes from suburban and urban areas. To date, most rural health studies have focused on health service access, rather than population-based prevention strategies. This may be because the primary emphasis in rural areas has been on clinical care and access to services and creating policies in these areas (Hartely, 2004). Yet, many of the major public health problems faced in rural areas, as noted above, are not likely to respond to increased access to clinical care. Phillips and McLeroy (2003), suggest that rather than focus on clinical access there is a need for a population based focus to address major chronic disease issues in rural communities. It is unclear how rural communities, including rural local health departments (LHDs), are addressing chronic disease apart from clinical care. The case for how population-based policy work as employed through CTW is implemented in rural areas needs further exploration.

In concert with this call for community transformation through PSE change, there is also a call for increasing the capacity of the public health workforce to do this work. Decreased funding and resources for public health increases the demands on the existing workforce and requires capacity building and mobilization efforts (Barry, 2008). With national and state funding for CTW, LHDs have the potential to play a major role in alleviating the burden of chronic disease; however, these additional responsibilities require changes in infrastructure, priorities, and competency. Taken together, reduced resources, competing priorities, and long-standing workforce issues are putting a tremendous amount of pressure on LHDs (Prentice & Flores, 2007). Some state and LHDs have received prevention funding through Community Transformation Grants from the CDC to address population-based chronic disease strategies with community-based coalitions. However, it has been found that many LHDs often do not have a well-developed infrastructure to address chronic disease at the population level (Prentice & Flores, 2007). Thus, it is unclear how prepared LHDs are for this work and how this work is actually getting done. They go on to point out that, a major factor that has been essential to build chronic disease prevention capacity at LHDs is committed leadership (Prentice & Flores, 2007).

At a LHD, the health educator is often responsible for primary prevention efforts. At the local level, health educators have the potential to lead change in this area by the resurgence of the social-ecological model through PSE change and the availability of new prevention funding streams at the national and state level. For many years, health education programs have focused on individual behavior change, assuming that if you teach people what will make them healthy, they will be able to do it. Being healthy is not just shaped by individual choices but is also shaped by the policies and environments around individuals (Cook County Communities Putting Prevention to Work (CPPW), 2010; Green & Krueter, 1990). Health educators have done well addressing individual and group behavior change, but health education practice is changing in response to emerging research that calls for a focus on strategies to address the underlying determinants of health (Fielding, 2013). CTW is an example of such a strategy. Public health educators are uniquely positioned to undertake and lead these strategies because of their understanding and specialization in changing health behavior (Lieberman, et al., 2013). Lieberman, et al., 2013, reflected upon this, saying "the public health literature has increasingly called on practitioners to target the contexts in which people live as a means of improving population health, yet models describing the scope, design, implementation, and effectiveness of such efforts remain limited" (p. 521).

For community transformation to succeed, organizations and practitioners must know and understand what factors effect implementation and what is needed for successful implementation. The role of health education in implementing PSE change strategies in rural communities is not well-defined. LHDs in rural areas may require guidance as they develop and implement strategies to support CTW through health education. Understanding the role of health education and the factors that effect this role may help to build the case for improving LHD capacity in health education, including developing leadership skills, and building support fora shared vision that health education can support.

## **2. Conceptual Framework**

There are several guiding frameworks for this study, including the social-ecological model, organizational theories, and health education and promotion capacity theories. Community transformation is rooted in the social-ecological model that focuses on the complex interaction between individuals, organizations, communities, and environments (Flaman, et al., 2011; Rivera and Birnbaum, 2010, Green et al, 1996, McLeroy, et al, 1988). The social-ecological model gives a framework to understand the importance and relevance of a variety of distal factors that impact health and the adoption of healthy behaviors, it is a framework and does not address specific issues related to intervention design or implementation, or what factors influence implementation.

Understanding the factors related to implementation is a key component to the success of an intervention and assessing the internal and external validity of interventions (Saunders, Evans, and Joshi, 2005; Durlak & DuPre, 2008). Implementation research has been gaining attention and recent efforts have focused on: 1) defining or assessing roles of public health agencies, 2) capacity building activities, and 3) understanding public health performance, including levels of implementation. (Durlak & DuPre, 2008). Understanding the role of the health educator in implementation and the factors that affect their role in implementation is central to this study.

Organizational theories of change provide the insight or framework to study implementation factors. Based upon their efforts to implement community-based cardiovascular disease interventions, Riley, Taylor, and Elliot (2003), proposed a theory of organizational change theory that centers on the organizational contexts including organizational culture, policies, leadership and the environmental context including partnerships. This study used their theoretical framework to investigate the relationship between implementation of health education work and the organizational context within which that work is implemented.

In addition to organizational theory, health education and promotion capacity theories will also be used in this study. The capacity to reduce chronic disease through CTW is dependent on several factors at the individual, organizational, and community level. Capacity is an important factor for successful implementation of prevention strategies. (Durlak & Dupre, 2008). Capacity for health education and promotion is complex and includes having the knowledge, skills, commitment, and resources at the individual and organizational levels and in the wider environment to conduct effective health education (Woodard, 2004). Organizational capacity for effective population-level health education work is not only the sum of individual capacities but includes organizational structures and policies which determine the patterns of relationships between individual practitioners, and also their organizational environment. Organizations facilitate certain individual actions and inhibit others. They can motivate and reward practitioners, help them develop their individual capacity, enable them to increase collaboration from working with others, and facilitate their access to resources.

A facilitating factor is defined as any factor which assists, stimulates, or provides support to the individual, organization, or community to achieve success towards meeting strategy objectives, thereby making a positive contribution to capacity. (Robinson, et al., 2006). A barrier to success is defined as any factor which hinders or creates a challenge to the individual, organization, or community to achieve success towards meeting strategy objectives, thereby impairing capacity. (Robinson, et al., 2006). Organizational factors such as culture, structures, and resources can have a very important effect on individual practice, which, in turn, is affected by environmental factors imposed by social and political structures (Woodard, 2004). With greater organizational and individual capacity, organizations such as health departments will be better equipped to implement CTW and PSE change strategies, build healthier communities, and ultimately improve health outcomes.

Based on these theories and frameworks, the main constructs and factors in this study are:

1. Health Educator:
  - a. Activities and management related to implementation
  - b. Practitioner capacity
2. Organizational constructs:
  - a. Structure
  - b. Culture
  - c. Resources

### 3. Methods

This study utilized a qualitative exploratory multiple case study approach, in which each participating LHD is conceptualized as a case (n=3). A case study is a qualitative method which is appropriate when a study seeks to describe, interpret, and explain study sites, participants, and processes in order to provide an in-depth understanding of the topics of interest (Lee, 1999). According to Yin (2009), "case studies are particularly helpful when 'why' or 'how' questions are proposed, investigator has little control over events, and the focus is on a contemporary phenomenon within a real-life context" (p. 4). This current study meets these conditions. The multiple case study approach helps to increase the explanatory ability and generalizability of the data in the study (Miles & Huberman 1994).

The primary sources of data included: document review of applications for the We Choose Health CTW grant and quarterly report; semi-structured key informant interviews with LHD staff; and observations of health educators. In addition, case study participants reviewed the preliminary findings for accuracy.

#### 3.1 Program Setting and Case Selection

The CDC received money from the National Prevention and Public Health Fund to provide support to state and local communities through the Community Transformation Grant program, which was designed to enable awardees to design and implement community-level programs that prevent chronic diseases including cancer, diabetes, and heart disease. (CDC, 2012). In 2011, CDC awarded \$103 million to 61 state and local government agencies, tribes and territories, and nonprofit organizations in 36 states, along with nearly \$4 million to six national networks of community-based organizations (CDC, 2011).

The Illinois Department of Public Health (IDPH) received \$4,781,121 each for fiscal years 2011 and 2012. IDPH branded their community transformation grant *We Choose Health* (WCH) and provided a funding opportunity to local communities in rural and suburban Illinois. In the Request for Applications, IDPH set three broad goals (IDPH, 2012):

- Increase nutrition and physical activity in communities;
- Increase opportunities for environments that support physical activity; and
- Increase access to smoke-free environments.

In fiscal year 2013, 21 grants were awarded to 60 rural counties, totaling \$3.5 million in funding (IDPH, 2012). Twenty of the 21 grant awards went to rural LHDs and their partnering coalitions. For the multiple case study design, the major units of analysis were LHDs in rural Illinois (n=3), with the sub-units being health educators. Cases were selected from the rural LHDs receiving funding through the We Choose Health Initiative of the Illinois Department of Public Health. Case selection was based on population reach, strategy focus areas, and funding amount. The cases in this study were purposively selected as they were all mid-sized LHDs, did not have more than three LHDs in their collaborating coalitions (thereby avoiding the effect of regionalization), and were deemed capable of providing insight into the key concepts in this study. In addition, selection was made with the understanding that the performance of a LHD is influenced by many factors with key factors being jurisdictional size and funding (Erwin, 2008); the selected cases were deemed to meet this criterion also. By choosing cases that were similar in these ways, it was possible to analyze a case within its setting and to then draw conclusions across cases.

### 3.2 Analysis

Utilization of multiple sources of data allows for triangulation and multiple cases allows for comparing and contrasting the results from each case to the other cases. The major conclusions from each case were analyzed using a five-step approach from Miles and Huberman (1994). This included reading and reviewing for general understanding, organizing data around main study questions, and categorizing based on the research questions and constructs in the study. The final analysis involved attaching overall meaning and significance to the data. A list of key points was summarized for each of the major constructs. In addition, new themes that emerged were summarized. In addition, once all data was collected and analyzed, the results were vetted through the participants to ensure findings, and recommendations were accurately reflected. Once each case was analyzed, themes and patterns pulled out, and summarized, the researcher looked across cases for overall patterns based on the research questions and constructs. This allowed for cross-case conclusions and findings to be made in the final cross-case report. The last phase of analysis included vetting the results and findings with the key informants at each participating LHD. Their feedback and responses were incorporated into the final results, findings, and recommendations.

### 4. Results

Health education is leading CTW at rural LHDs. Health educators are the ones “out in the community facilitating partnerships for change.” The partnerships that had been built up through primarily programmatic work, such as in the schools, provided for the perfect opportunity to expand upon what the rural LHD could offer through policy development and change. One respondent noted, “health educators have such an important role because they get to do the work that is really tailored to your community and addressing the new issues that come up and any of the new grants are mostly in health education.” Table I summarizes the key findings from this study around the role of health education in CTW, and the factors that may affect this role including resources, organizational structure, organizational culture, and capacity.

**Table I. - Results Summary**

Main Study Questions	Major Findings
How is CTW organized and managed at the rural LHD?	<ul style="list-style-type: none"> <li>• Health education work and health educators while valued, there is not sustainable funding for their positions.</li> <li>□ Resources in terms of staff and funding continue to be a challenge at rural LHD.</li> <li>□ The narrowed view health education just doing programs seems to be changing in rural LHD because of CTW.</li> </ul>
What is the role of the health educator in CTW at rural LHD?	<ul style="list-style-type: none"> <li>• Health educators are leading CTW at rural LHD, but did not feel prepared.</li> <li>□ CTW shifts the focus from individual level programing and change, to organizational level programing and change in line with the social-ecological model and systems view.</li> <li>□ There seems to be a view that policy work and PSE change is new to health education work in rural LHD, but it is an essential responsibility as laid out by NCHEC.</li> <li>□ Leadership skills and traits are essential to build necessary relationships to implement PSE change...both at practitioner and administrator level.</li> </ul>
How do organizational factors affect the role of health educator in CTW implementation at rural LHDs?	<ul style="list-style-type: none"> <li>• CTW and health education work is valued in rural LHD.</li> <li>□ CTW and health education work align well with LHD mission, vision, and main community health priority areas in rural LHD, of which all included chronic disease prevention.</li> <li>□ Resources in terms of staff and funding continue to be a challenge at rural LHD.</li> <li>□ Community partners and relationships are crucial in rural communities</li> </ul>

Lack of funding was a common theme as noted by respondents. Many respondents were hopeful that new grants would emerge once funding ended. Lack of funding has become the norm for LHDs. The larger issue in terms of resources was staff and time to do the “enormous amount of work” that is required of CTW. “It is hard not to feel like failure when bigger LHDs are doing more– but they have more time, staff, and funding and you just can't physically get it all done.” Table II summarizes some of the key illustrative quotes from respondents about the role of health education in CTW and factors that affect this role.

One respondent noted, “Health education and health promotion is really about funding their time, since they don't need a lot of physical stuff, it's not about much else. We need them, their time, and expertise to build relationships, to get policies passed and programs implemented.” However, there was also a common theme that health education work is seen as “extra” in the health department. In addition, “while this is important work, it's not necessary work needed in order to run a LHD.” All respondents would like to see a system in place at the state and or federal level to support “real sustainable health education.”

**Table II. – Illustrative Quotes from Respondents**

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“Health education is a natural fit for this type of work since it falls in line with the principals of what health education does. They help to motivate and facilitate community partnerships to make change in the community.”

“It was so great to have just identified obesity as a priority and see state funding mirror this priority since that doesn't often happen. We often have no real money to help implement and support the priorities set out in IPLAN.”

“Health education has such an important role because they get to do the work that is really tailored to your community and addressing the new issues that come up and any of the new grants are mostly in health education”

“While this is important work it's not necessary work needed in order to run a LHD.”

With more sustainable funding sources, “Only then will we see the true potential of what we can do as a LHD in terms of health education type work.”

“Health education and health promotion work doesn't always show up as a funding priority and “that makes the work hard to sustain if we don't have funding to support staff.”

“It's going to be hard when the WCH funding goes, since we made promises to schools that were unsure about working with us because of the nature of grants. So it may continue but not at same level because not all our staff will be here to keep pushing and helping. And I think it damages community relations when funding is cut like this. They lose faith and trust in the health department.”

“Having an established coalition of partners was very helpful and a great resource. These members are our community and are vital to our success. You can't ignore coalition building in this type of work.”

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Issues and ideas specific to rural communities and rural LHDs engaged in CTW work also emerged. There seemed to be a general theme that “just because we are rural, doesn't mean we can't get things done.” Study participants saw that the small scale of the rural community could be a facilitating factor in accomplishing CTW. According to one respondent, “a side from our numbers being smaller, I don't think rural has anything to do with us being able to accomplish these PSE objectives because you come in and you just get used to how it is. You get to know your community and what is doable and that won't necessarily be the same as an urban county, but that is ok. We adapt.” It appears in these cases, that rural is still very much misunderstood. One benefit or facilitator noted repeatedly was the idea of knowing and understanding your rural community and building relationships. One participant said, “we are from here. We know this community. People trust us and we are a familiar face.” Further, “rural public health is about relationship building, and that is why your coalition and partners are so important. Making connections is key.” As shown in Table III, activities related to CTW implementation by the health educator aligned with NCHEC health education responsibilities. The implementation of PSE change often starts with assessing the need within the organization or community, and proceeds through a set of steps, up to and including planning or developing appropriate policies, involving stakeholders, advocating for their passage, and ensuring implementation. These activities are congruent with the responsibilities and competencies of a health educator, according to NCHEC.

**Table III – NCHCEC Seven Areas of Responsibility and Relevant Examples**

Seven Areas of Responsibility	Example of Activity
Assess Individual and Community Needs for Health Education	Help to implement the school health index; Support and promote of Illinois youth survey(IYS) data; Assess needs of staff for workplace wellness programming and policy; Identify local data to support policy
Plan Health Education	Discuss planning in regards to how workplace wellness would work in school setting; Plan how to approach officials with safe routes to school plan; Develop policies; Involve stakeholders and coalitions in planning
Implement Health Education	Provide background information on chronic disease, why this is important, demonstrated how an Internet based program wellness worked; Present information to county board on importance of smoke-free public places; Provide information to coalition members on PSE change.
Conduct Evaluation and Research Related to Health Education	Illinois Youth Survey; Research new and emerging issues to keep on radar; Conduct process evaluations on how program and policies implemented; Complete performance reports
Administer and Manage Health Education	Manage budget for CTW; Write performance reports; Manage coalitions; Facilitate CTW partnerships
Serve as a Health Education Resource Person	Serve as key resources in the community for strategy areas; Empower and lead coalition members through education and resources to implement PSE change strategies
Communicate and Advocate for Health and Health Education	Provide opportunities for coalition members and community members to be involved; Advocate for policies at workplaces, schools, and in communities; Help develop policies for smoke-free parks, schools, and workplaces

Most practitioners had little to no experience in “policy type work.” Most had previous experience in programmatic type health education, including health education in the school classroom on topics such as tobacco cessation or cardiovascular health. Some noted experience working on current tobacco prevention policy project under a grant that was aligned with the objectives of the WCH grant. During follow-up, respondents were asked if they thought health education was experiencing a shift to a more PSE change focus. According to one respondent, “health education seems to have been focused on programs and education, now there is big push for policy and proving effectiveness– and has been sort of barrier because our thinking isn't policy driven usually. “This comment supported the emergence of a theme concerning a recent change in focus from a programmatic approach to one that stresses organizational change and education of policymakers, school officials, and community leaders to make PSE change happen. “There is more pressure from grants to do policy work and more evaluation.” While a shift was noted, many expressed that they felt PSE change work should occur in addition to, not instead of, individual or classroom based health education. “As health educators – this is what we do, we are supposed to be in schools, be out in community and making change...this is what we do. “Another respondent stated, “I think this work is so important and it's really a game changer for us in health education or hope it can be.”

In terms of knowledge, common themes included knowing and understanding your community; knowing who the key players are; strong understanding of health; and understanding the political environment. This was further confirmed through observation which showcased the health educators and demonstrated their knowledge and understanding of the community and issues. One administrator said, “Health education is more valuable than ever before, and then that makes our health department more valuable to the community. So it is a win-win for all.” Another administrator noted, “Health education and promotion is often considered extra position but is so vital and there is so much potential in their work. They are becoming more integral into public health. So in that way this push towards environmental change really helped us solidify the role of a health educator.” Respondents reiterated the importance of good relationships with community partners; this emerged as a strong theme. As the health, educators were often the people interfacing with the community, the job of relationship building fell to them. One respondent noted, “It is key to build relationships and get buy in from partners. They are huge allies and if they trust you, they will be willing to work with you and for you.” They found that working with community partners allows staff to learn about the community and what they need.

## 5. Discussion

Health education, whose roles leading CTW implementation are valued at the rural LHD, still face unstable funding. Without sustained funding the start and stop, nature of their work may continue and it may undermine efforts to reduce chronic disease. Rural LHDs may benefit from a regional approach to CTW to ensure sustained funding and resources so that the work can continue. In addition, changes made at the state or national level could be made to create a more sustainable fluid approach to funding health education. A shift towards a more policy focus in health education is evident in rural LHDs because that is what “new” grants are calling for and it falls in line with the national priorities towards a more systems based approach in chronic disease prevention. Not all the health educators felt ready or prepared to do this work. However, because of a diverse set of skills, traits, knowledge, and experience working in the community, they were able to “rise to the occasion.” This speaks to the leadership skills needed by practitioners to carryout CTW to include flexibility, strong communication skills, and a strong passion for this work to be that change agent to lead their communities to be healthier. And it is the knowing and understanding your rural community and working closely with community partners, that LHDs credit to be the most important assets to be successful in CTW in a rural setting.

Further, CTW aligns well with the principles of health education and promotion; at its core, CTW is about enabling people, organizations, and communities to increase control over their health and the health of their communities by changing the landscape in which they live, work, and play (WHO, 2009). This is a foundation in health education and promotion. In this study, health educators were uniquely positioned to undertake and lead these strategies. Their understanding and specialization in changing health behavior can help them to understand how to change organizational and community systems (Lieberman, et al, 2013). Where they were once primarily focused on individual behavior change (one level of the social-ecological model), CTW allowed them to address issues across domains and facilitate change at the organizational, community, and health policy levels. In this study, health educators were viewed as the ideal people to implement CTW and, across cases, were the ones selected by their LHDs to do so. Participants in this study agreed that health education cannot focus solely on policy development and implementation. Health education is a key community need and, when linked with broader efforts, it can be utilized as a gateway to building support for policy change initiatives. To be effective, health education cannot solely focus on education and PSE change strategies cannot achieve policy change when those efforts are divorced from the comprehensive needs of a community. Policy change and health education are inexplicitly linked (today, as they have been historically) (Lieberman, Golden, & Earp, 2013). In this study, it appeared that the cases had a set idea that education was primarily about individual-based or classroom-based education. They had come into CTW with a bias against recognizing that policy-focused interventions aimed at an organization or the broader communities were in fact health education. As noted by one respondent, “this wasn’t what I signed up to do as a health educator.”

Time will tell if this work changes the role of health education overall in rural LHDs, but many saw CTW as promising and areal “game changer” for the profession. There is still work to be done to secure sustainable funding to keep health educators at rural LHDs. It was also evident that rural LHDs value these practitioners and their work, but funding now for them is only through state or federal grant money. Further, there does not seem any evidence that the way health education work is funded in rural LHD will change. There will continue to be this brutal start and stop nature of the grants, and when grants end it may mean cutting that position and stopping the work the grant funded. This vicious cycle hinders long term change towards healthy communities, the prevention of chronic disease, and according to most cases, hurts the LHDs reputation and ability to work with local partners. An important question becomes, how can we continue to support health education at rural LHDs and also across the public health system to continue to lead this work and drive change in communities?

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