Perceptions of Evaluator Competencies in Public Health

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Abstract

Public health is a profession that typically provides services through government and is complex, expensive, and often political. The public health profession usually consists of professionals, such as nurses and health educators. Evaluation is a component of public health services and is often conducted to demonstrate the value of a program's services. The evaluation field exists as its own practice that also has professionals, competencies, and ethics. Evaluation in public health may be conducted by public health staff or may be contracted to another party. It is important that evaluations of public health programs be conducted with rigor and expertise because of the potential impact to society and the magnitude of costs if they are not.

The purpose of this study was to find out what public health professionals think are the most important competencies for those who conduct evaluations for public health programs. The methodology of qualitative inquiry included focus groups of public health professionals in Minnesota with oversight of evaluators and evaluation. The methodology of quantitative inquiry consisted of an electronic survey of members of the Minnesota Public Health Association. Results of this study show varying opinions of what is most important in public health evaluator competency traits and that all are important. The results have implications for public health practice and future research of evaluator competencies.

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Chapter 1. Introduction

Public health programs cost taxpayers almost $1 billion in 2014 from the United States Prevention and Public Health Fund (United States Department of Health and Human Services, 2014). Public health is a population-based science that protects and improves the health of the population through activities such as infectious disease prevention, sanitation, and community health promotion (Public Health Foundation, 2014a). In the United States, public health is structured through federal, state, and local government agencies and uses taxpayer dollars to carry out its 10 essential services at the federal, state, and local levels. The 10 Essential Public Health Services describe the activities public health should undertake and have three foundational areas: policy development, assurance, and assessment (CDC, 2014). Evaluation is one of the essential services under the assurance category and is considered a cornerstone for improving public health programs; however, it may not be the top priority for the service manager of a program. Harris (2010) pointed out:

> One major assumption in evaluating an initiative is that it was well planned and fully implemented. This, however, is not always the case, and the evaluation team may find it must balance the expense associated with undertaking the evaluation with the likely result of the evaluation. (p. 5)

Wholey (2015) listed three primary reasons evaluation is used in government: to increase transparency, to strengthen accountability, and to improve performance. Under the current federal administration, there are ongoing initiatives to continually modify and improve evaluation. However, there are challenges that affect these attempts, such as institutional and political challenges; competing interests; organizational changes; and

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lack of cooperation for coordinating, collaborating, and willingness to use evaluation results.

Public health programs are not exempt from the challenges of evaluation and confront them at all government levels. Three examples of high-priced public health programs that included evaluation and may have dealt with one or more of these challenges are:

1. SNAP- The Supplemental Nutrition Assistance Program (SNAP) is a U.S. federal nutrition assistance program that works to alleviate food insecurity and improve nutritional intake of low-income individuals. In 2011, 44.7 million people received benefits. In a review of 17 studies between participants and non-participants in SNAP, there was little to support overall energy or nutrition intakes (Leung et al., 2014). The Leung et al. study identified data collection shortcomings and recommended that initiatives should be implemented and broadened. However, no recommendations on how to evaluate this further investment were suggested.

2. Teen pregnancy- Teen pregnancy, which is associated with negative consequences for the children of the adolescent parents -- such as the expense of foster care and a higher need for health care -- costs taxpayers $11 billion each year (Lachance, Burrus, & Scott, 2012). Lachance et al. go on to explain the deep complexity of evaluating programs that serve adolescent mothers and their newly created families. Evaluation is needed in order to inform program planners about what is effective and under what conditions to change the costly issue of teen pregnancy.

3. DARE- The Drug Abuse Resistance Education (DARE) Program is the most

    widely used school-based substance abuse prevention program in the United

    States. It is funded by many sources, including federal dollars, costing over $400

    million to help alleviate a $2.1 billion drug problem plaguing the U.S.

    (Government Accountability Office, 2003). Despite the significant investment in

    the DARE program, the Government Accountability Office (2003) found little

    significant difference in students who received DARE training and students who

    did not.

Statement of the Problem

Increasingly, the federal government has required agencies at the federal, state,

and local levels to evaluate agency performance in relation to specific accountability and

program outcome measures and metrics (Burwell, Munoz, Holdren, & Krueger, 2013;

Newcomer, Hatry & Wholey, 2015; Orszag, 2009; 2010). While the development and

adoption of performance measures have helped agency administrators to identify what is

to be measured, concern remains for who is to be called upon to design and implement

these evaluations. The problem addressed in this paper is that while complex community-

based health programs, services, and interventions can be challenging and expensive to

evaluate, there is a critical need to ensure that professionals possess the essential

competencies needed to conduct high quality and technically sound evaluations of these

programs and services.

Considerable variation in knowledge, skills, and competencies among individuals

who claim they are "professional evaluators" currently exists nationwide (Stevahn, King,

Ghere, & Minnema, 2005). The Joint Committee on Standards for Educational

Evaluation has advanced standards that evaluators should ideally meet; however, universal adoption of the standards and competencies has not occurred in the United States (Stevahn et al., 2005). Because of this, an agency seeking qualified evaluation services may have to assume the responsibility for assessing the extent to which the evaluator possesses the knowledge and competencies to plan and carry out the evaluation. The hiring agency may or may not be aware of the evaluator competencies applicable to their program's context, which could affect the desired outcome of evaluation. A cue from a potential applicant of evaluation knowledge could assist the hiring agency with this.

It is the current opinion of evaluators that accreditation, certification, and credentialing (ACC) of evaluators may not necessarily improve program outcomes due to lack of sufficient evidence (Shackman, 2015). There is also a lack of support from current evaluators to implement any sort of ACC (Shackman, 2015). External evaluators, for example, may find themselves in an unfavorable program environment where they are unable to produce quality evaluation work due to a non-receptive, non-evaluator friendly environment (Newcomer, Hatry, & Wholey, 2015).

The Context: Evaluation of Public Health Programs

It is important for evaluators to know the context in which they are evaluating so that their evaluation may be used effectively (Rog, 2012). Weiss (1998) provided reasons for why it is beneficial for an evaluator to understand context. She commented that it is important for an evaluator to develop a good sense of the issues being evaluated, formulate relevant and inclusive questions, assist in understanding the data, interpret evidence, make good recommendations, and provide reporting for meta-analysis (if being

conducted) (p. 47). All social programs and organizations operate with different levels of complexity and a range of factors influences their operations.

Earlier in the 20th century, public health programs in the U.S. recognized the important role of standardizing evaluation practices in the field by creating a Committee on Evaluation and Standards within the American Public Health Association (Greenberg, 1958). This attention aligned with the priority and funding that evaluation was beginning to receive by the federal government during the time of the well funded Great Society programs in the 1960s and 1970s (Stevahn et al., 2005).

As mentioned previously, evaluation is an essential component of U.S. federal government programs, yet is not standardized in its practice or implementation (Government Accountability Office, 2013). This has been a concern within the public health field in which evaluation has been included within the core principles and standards for guiding federal, state, and local health service activities (Centers for Disease and Control, 1999). This is a critical issue affecting the practice of evaluation because the key reason for the federal government mandating and funding evaluation was to formulate public policy and show outcome value for program investments (Fitzpatrick, Sanders, & Worthen, 2011). Unfortunately, many government program managers are not evaluating programs due to a limited understanding by managers of the role evaluation plays in developing an understanding of agency and/or program performance (Government Accountability Office, 2013).

In the U.S., evaluations conducted by the state and federal governments vary significantly in their level of rigor and quality. For example, in the early childhood education setting, evidence of evaluation effectiveness varies, with the most recent study

of methodology inconsistencies dating back to 2001 (Ustedt, Epstein, & Barnett, 2013). A meta- analysis of impact evaluations of state preschool programs by Gilliam and Zigler (2001), where out of the 13 states studied, 7 were done by outside, third-party evaluators, and 6 were conducted by state education departments. In this case, all evaluations varied state-to-state in their methodologies, rigor, and findings. Results from each state's preschool evaluations ultimately informs policy makers about the future design and development of preschool programs and can have a major impact on families that need these services (Gilliam & Zigler, 2001). Evaluation itself within public health can be complicated because of the multiple ways in which needs assessments are categorized based on the type of need: social, epidemiological, behavioral, environmental, educational, administrative, and genetic. Evaluators must draw on the science of each of these disciplines and the differing methodologies applicable to each in order to conduct valid evaluations (Fink, 2013).

In public health, there are many stakeholders in the evaluation process. The Centers for Disease Control and Prevention (2012) identify three major groups:

1. Those involved in program operations: management, program staff, partners, funding agencies, and coalition members.

2. Those served or affected by the program: patients or clients, advocacy groups, community members, and elected officials.

3. Those who are intended users of the evaluation findings: persons in a position to make decisions about the program, such as partners, funding agencies, coalition members; and the general public or taxpayers.

In the absence of standards or criteria for certifying the knowledge and skill levels of evaluators, program and agency heads must make decisions to engage an evaluator based on their own, and, many times, limited knowledge of evaluation practice. This may result not only in program and agency dissatisfaction with the evaluator and how the evaluation was conducted, but may also and, more seriously, result in producing inaccurate and/or erroneous results regarding the performance or impact of a program and/or service. Evaluation is an intrinsic component of a comprehensive health care system and the components of evaluation must be built into it (Tulchinsky & Varavikova, 2014).

Public health recognizes other professional certifications in its practice, such as physicians, nurses, sanitarians, and other allied health practitioners although this can vary country to country. Public health is a combination of political will, health leadership, and financial and organizational systems that need well-trained staff in planning, management, population health monitoring, and health system functioning (Tulchinsky & Varavikova, 2014). Publicly funded programs require demonstration of diligent evaluations in order to demonstrate their effectiveness. In order to achieve this, uniformity of evaluator competency by those who conduct them is needed.

Purpose of the Study and Research Questions

The purpose of this study was to identify the perceptions and value of evaluator competencies as they relate to the profession of public health. The research questions to be addressed in this study were:

1. What are the current perceptions of public health administrators in Minnesota about the skills and expertise of those who conduct evaluations?

2. What do practicing public health professionals view as the most important

   evaluator competencies for public health evaluators?

Significance of the Study

This study has theoretical significance that contributes to the discussion of concerns evaluators have in advancing evaluation practice and its move toward professionalization. In a recent article by King and Stevahn (2015) the authors recommended looking at evaluator competencies used in other contexts. The results of this study provide empirical evidence about the value of evaluator competencies in the profession of public health. This is valuable because these discussions typically take place among evaluators and not in a specific profession that uses evaluation services. In a survey conducted in 2014 of members of the American Evaluation Association (AEA) about their opinions on feasibility, need, and potential for establishing evaluator certification or credentialing, it was found that their opinions on the topic had not changed much since AEA members were surveyed 16 years earlier, when they had mixed concerns about the topic. Concerns noted from the 2014 survey included: worry of the financial expense of becoming certified/credentialed, narrowing of the profession, mixed views on evaluator assessment to qualify for a certificate/credential, and the mix of contexts in which evaluators conduct evaluations (Seidling, 2015).

The results of this study contribute to the limited evaluation research conducted about context. Vo and Christie (2015) acknowledged that many components of evaluation have been studied over time but there are still topics that need more in-depth exploration, such as context. The study conducted for this paper will contribute to the discussion the evaluation profession is having about these topics. This study may also be helpful to any

of the three major public health stakeholder groups mentioned previously, especially those that fund or hire evaluators. The results could be beneficial to evaluation decision makers like members of the American Evaluation Association, as they consider accreditation, certification, or credentialing in the United States.

Definition of Terms

Accreditation: Formal review of a preparation or education program conducted at periodic intervals to ensure that it meets the standards of a profession or discipline (Altschuld & Engle, 2015).

Certification: Verification of a person's competence on specific knowledge and skills usually by a test. Recertification later on in the profession may include the need for continuing education credits (Altschuld & Engle, 2015).

Competence: A concrete concept that includes knowledge, skills, or attitudes and speaks to the quality of being physically or intellectually qualified (Wilcox & King, 2013).

Credentialing: Specifies that a person has knowledge, skills, and practical experiences worthy of a credential by portfolio review from other professionals in the same field (Altschuld & Engle, 2015).

Licensure: The right to practice in a field with compensation confirmed by a governing body or government (Altschuld & Engle, 2015).

Professionalism: A set of institutions that allow professionals of an occupation to make a living while they control their own work (Freidson, 2001, p.17).

Chapter 2. Literature Review

This chapter provides a literature review of the evolvement of public health and evaluation as a profession. Public health has a long history of growth and adjustment as science has advanced and populations have changed. Evaluation is discussed as a newer profession that continues to mature and make decisions about it's own professionalization. Various competency models, which are foundational guides for professionals in which to conduct their work, are laid out and include classic competency models and others. The last section of this literature review presents three theoretical perspectives which are professionalism, evaluation competency, and signaling theory.

History of the Health Professions

The history of medicine and the discussion of professionalism, credentialing and its impact on other fields of work are described in great detail by Freidson (1988, 1994, 2001). Early medicine was considered an independent profession. Practitioners were self-employed because of their ability to determine the terms and conditions of their work. This has shifted over time with the direct consumer and practitioner relationship evolving into a multi-tiered system involving insurance, government, and other complex components of our current healthcare system. The profession of medicine is not organized in a hierarchical management structure. Rather, medicine has occupational authority that can influence or give authority to other professions, described as an interdependent technical enterprise. However, this interdependence does not erode the dominance of each other's skills (Freidson, 1994).

The Sanitarians: A History of American Public Health (Duffy, 1992) provides a rich background to the rise of the public health field as it was merging with physicians

and medicine and forming practice and policy. Diseases were on the rise in the United States during the 1700s as more people were arriving in the country as immigrants. The terms *public health* and *sanitarians* were not yet used, however; "scavengers" was the name for the professionals responsible for assisting residents with street cleanup in the new cities. It was during the late 1700s that Duffy reports the medical profession was on the rise but the physician had very limited knowledge and understanding of pathogens and vectors. Medical societies were beginning to appear, thus giving the profession some cohesiveness. Medical practitioners were still trying to understand vital statistics and common community health problems. They needed to accomplish this before fitting into the public health setting. Ultimately, since physicians were pulled into the emerging public health system, they and their medical societies began to shape the field.

It was not until the 1800s that other advances in science, such as math and chemistry, helped forward the field of medicine and did not create a threat to the medicine field. The influenza pandemic of 1918 was a backdrop for the detailed historical account of the rise of medicine. These times were described as becoming chaotic in the medical profession, and, although there were a lot of available physicians, very few were licensed (Barry, 2004).

Barry (2004) described how in 1870, a Harvard medical student could fail four out of nine courses and still become an M.D. and that there were very few medical schools. Also during this time, medical institutions did not support any medical research. The first funding of the Johns Hopkins combined hospital and medical school in 1893 was pivotal to moving students from learning what was believed to actually testing and studying science. In 1908, the American Medical Association (AMA) commissioned a

member to study the medical education that existed in America. "The Flexnor Report" found that 120 of the 150-plus schools operating should have closed because of such low standards. This era was considered the Progressive Era during which professions were becoming organized; medicine should have been included. The AMA began rating schools as Class A, B, or C while states began denying licenses to Class C school graduates. The AMA earned the credit for reorganizing medical education in this country and advancing professional standards for entry into the medical field (Barry, 2004). Today, physicians must meet minimum competencies aligned with their certification in order to apply for a license to practice medicine (Altschuld, 1999).

Another core profession within public health is the sanitarian. Public health sanitarians were recognized as workers dedicated to the prevention of transmittable diseases once it was understood how diseases were spread in the human population (Koehler, 1919). In an editorial in the *American Journal of Public Health* (1926), comments were shared about a food inspection study of all the various state laws in the United States and that these laws were useless unless administered by the right professional. The editor commented that while there were good regulations and law, the personnel implementing it ranged from attorneys to farm breeders. There were no standards for personnel conducting inspections, which led to problems because of the risk of adulterated foods. Public health and safety evolved during this time to include politics and profit margins, which deterred the principles of health and safety in food processing. The editor concluded that one should be well qualified to do the work of an inspector, pass an exam to demonstrate knowledge, and not be replaced due to political influence.

The American Public Health Association in the early 20th century discussed the need to understand and sort out the purpose and value of identifying minimum core competencies needed for a sanitarian's standard of practice (Hauge, 1928; Ogden, 1953). Hague (1928) notes that the Sanitary Inspectors Association of Canada had done a good deal to improve the status of sanitary inspectors by offering opportunities to increase their knowledge, usefulness, and status so that any uneducated person could not become a sanitary inspector. He went on to compare the lack of Canada's oversight to England, where very specific standards, education requirements, and testing were required. He discussed the desire to raise the status of the profession by providing education, obtaining technical skills, and becoming certified. Because of the sanitarian's role in protecting the public's health and as a daily spokesperson with citizens, he or she must be well qualified.

Ogden (1953) describes the rise of public health sanitarians in England and how professional standards and requirements evolved. Many years ago, sanitarians could come into the field of practice whether or not they had educational qualifications, which Ogden explained has changed (p. 1509). Sanitarians must now pass an exam given by an examination board, have approved education requirements, and have attended board-approved courses at approved colleges. Minimum qualifications of practiced experience must also be presented, similar to internship hours. Ogden states that "a desirable high standard of theoretical knowledge cannot compensate for any failure to satisfy the examiners in respect to a thorough practical familiarity with the work and duties of a sanitary inspector" (p. 1510).

Once these standards were identified as requirements for entering the practice of a public health sanitarian, the results of a sanitarian's role in the public health field has demonstrated significant value in the prevention of major public health outbreaks in frequented public spaces such as restaurants (Irwin, Ballard, Grendon & Kobayashi, 1989). Currently, the National Environmental Health Association (NEHA) provides a national exam for the Registered Environmental Health Specialist/Registered Sanitarian and requires applicants to register as a sanitarian with minimum qualifications for application, including education and practice. Each state may or may not grant reciprocity to the national exam. If reciprocity is not recognized, the state will offer its own exam and sanitarian license (NEHA, 2014).

Other medical and public health professions have followed similar paths. Disciplines such as nursing and sanitarians have evolved over time into the professions they are today. Licensing and certification in these specialized fields within public health is required (Black, 2014). Currently, public health is a field that continues to evolve and develop. It requires specialists trained with an understanding of its evolution from earlier to current times, its scientific advances, concepts, and best practices. Current workforce examples include personnel such as physicians, nursing and midwives, dentistry, pharmacy, laboratory technicians, public relations, attorneys, and community health workers (Tulchinsky & Varavikova, 2014). All of these standard-setting developments that have occurred in the public health arena have done so as a means of advancing the competencies of professionals and, thus, advancing the efficacy of their various roles in society.

Professionalizing Evaluation

Evaluation is in a state of analysis and scrutiny as current professionals and theorists in the field discuss its professional status (Wilcox & King, 2013). This discussion is not new; as Worthen (1999) points out, that there has been some need for certification, credentialing, or licensure for decades. He points to the flaws in many evaluation reports that indicate the author's lack of competence in evaluation that are traceable to poor academic preparation, lack of experience, or lack of conscience. Many practitioners specializing in surveys, research, statistics, and other methods mistakenly assume their academic training prepares them with all the relevant experience to be effective evaluators (Worthen, 1999).

Altschuld (2005) comments on the various meanings of the terms *certification*, *credentialing*, and *licensure*. Certification is a formal process used to determine competencies for minimum levels where one can earn a "certificate." Credentialing is a set of courses or field experiences that are issued to show that one can perform competently. Licensure acts as a formal permission from a legal agency to conduct work.

Worthen (1999) presents four major challenges in implementing a certification concept: what approach should be taken, what competencies should evaluators possess, constructing certificate procedures and instruments, and garnering support. Altschuld (1999) presents a possible plan for evaluation credentialing asserting that it would assist in establishing boundaries for the profession. He states that it does not seem as threatening to evaluators to be credentialed as compared to being certified (p. 510).

College and university academic and professional evaluators have laid the groundwork to further advance the professionalization of evaluation in the United States.

Program evaluation standards, guiding principles, competencies, and ethics have been developed (Altschuld & Engle, 2015; King & Stevahn, 2015; Morris, 2008). A recent update of credentialing status, presented in an adaptive action model provided by King and Stevahn (2015), is organized by theory and practice. Theory updates are: (a) existence of validity evidence; (b) evaluation context within subject areas; and (c) improved practice. Competency practice updates include worldwide implementation and continued evolution in original drafts from the1990s, 2001, and 2005 (King & Stevahn, 2015).

In Canada in 2009, members of the Canadian Evaluation Society's (CES) National Council unanimously agreed to approve a model for their now operative CES Credentialed Evaluation (CE) Designation. It is a self-voluntary elected program that claims three foundational pillars: a code of ethics, standards, and competencies (CES, 2014). Currently, the CES has about 1800 members (Buchanan & Kuji-Shikatani, 2014) and 256 listed Credentialed Evaluators (CES, 2014). To obtain the credential, applicants pay a fee, meet minimum entrance requirements, and pass a final board decision. Underlying this credential is a foundation of 49 adopted competencies, based on the historical work of aligning them to education and experience to create the credential program (CES, 2014). In a 2012 survey of Canadian Evaluation Society members, Gauthier, Kishchuk, Borys, and Roy (2014) explored the characteristics of those who did or did not seek the Canadian Credentialed Evaluator designation and assessed intended and unintended outcomes. They found that newcomers to the field were the most interested in the credential while those more experienced had less interest. While the outcomes were still not fully realized within society, members of the CES felt positive

about the credential. Because the system of Canadian designation and competencies is still in its infancy, there is continued opportunity for learning about its impact (Kuji-Shikatani, 2015).

Other countries have identified evaluation credentials similar to those the United States has discussed. South Africa has developed evaluation standards and competencies that assist program managers, evaluation advisors, and evaluators in their governments. The purpose is to strengthen evaluation knowledge and skills, provide transparency in government, and support their relationship to evaluation consultants (Podems, Goldman & Jacob, 2014). The Japan Evaluation Society (JES) exists to provide accountability and transparency to the public sector with the primary activities of: holding a semi-annual conference to promote knowledge sharing; facilitate international evaluation sharing with evaluation experts; publish the *Japanese Journal of Evaluation Studies*; train students, government workers, and practitioners; and to facilitate an e-networking system (JES, 2016). New Zealand also has a competency framework system in place for evaluators through their Aotearoa New Zealand Evaluation Association (ANZEA). The ANZEA has created a workshop program to engage evaluators to become familiar with and use the competencies (Wehipeihana, Bailey, Davidson, & McKegg, 2014). While all of these countries provide competencies for the purpose of furthering the evaluation practice, Canada is the only country that has advanced to an evaluation credential. Laurie Stevahn, Jean King, Gail Ghere, and Jane Minnema (2005) proposed evaluation competencies have been identified for consideration in the United States, which were used in developing the Canadian standards; however, they have not been formally adopted by the evaluation profession in the United States.

Some evaluators may argue that there are going to be setbacks to credentialing in the field, but there are also recognized benefits (Altschuld, 1999; Jacob & Boisvert, 2010; Shackman, 2015; Worthen, 1999). One benefit would include a way for hiring employers to identify the level of evaluation training in public health job applicants. It could advance the overall evaluation field by having other disciplines substantiate evaluation theory and practice. Most importantly, it could better advance the state of evaluating public health and other expensive social programs.

Jacob and Boisvert (2010) point out the negatives of professionalizing evaluation, such as restricted diversity in the field, reduced training options, and barriers in accessing the profession. They go on to point out challenges of professionalizing evaluation that could occur, such as lack of a clear definition of what evaluation is and its contribution, difficulty in verifying expertise, and having to develop potential new structures or organizations. Altschuld (1999), in making his case for credentialing, also points out concerns that occur, such as the concept of "grandfathering," a practice of including long-term practitioners from a new requirement. This would exempt evaluation practitioners who may actually need the extra training. He also brings up the concern of credentialing replacing other better evaluation training programs that have more resources.

The path of professionalization in medicine and public health is fundamentally similar to that in evaluation. They are both complicated and non-linear. In addition, they get much of their grounding in real-life situations that by default need identified experts to conduct work effectively. While the research and theoretical literature discuss the problem of not credentialing or certifying evaluators, Canada is the only country in the world to have moved beyond these challenges to advance the evaluator into this level of

profession maturity. Similar to public health, evaluation has a history and more recently (in the last decade) is exploring the need in the United States for recognized professionalism, especially given its role in public health program work.

Methodological Issues for Competency Models

This section outlines classic competency models followed by considerations that affect their implementation. Competency models are based theoretically in behavioral psychology (Rothwell & Lindholm, 1999). Professions each have their own unique history and how we understand their current situations could vary. Early founders in the field moved thinking from intelligence tests to individual performance tests. Competency modeling has evolved from a theory of personal performance to an approach focused on improving organizational performance (Rothwell & Lindholm, 1999).

Classic competency models. The purpose of competency models in general is to either improve employee performance or the success of an organization or both (Kochanski, 1996; Rodriguez, Patel, Bright, Gregory, & Gowing, 2002). To organize collections of competencies to achieve their purpose, there has been a history of model development.

One approach is to simply look at models as a "single-job competency model" or a "one-size-fits-all model" (Mansfield, 1996). The single-job competency model is seen as the most common approach to job competency modeling. The process starts with an identified critical job that needs better selected candidates. There is a data collection phase that includes a focus group made up of jobholders and/or managers. This phase can also include interviews and surveys with customers and direct observation of jobholders at the workplace. Data are analyzed and then distilled into a competency model that

includes up to 20 job traits, each with a definition. Also included is a list of behaviors that describes what effective performers do and how they could achieve effective results. Prior to implementing this model into the organization, it must incorporate human resource tools and a program based on the model. Strengths of this model are: a framework for describing key job requirements, ownership of results from contributing managers and staff, and the ability to help staff understand what they must achieve to succeed. Weaknesses of this model include the cost and time it can take while jobs are evolving quickly. It can often have a shelf life of about 2 years. Another drawback is individual competency models are not always connected to an organization's other competency models (Mansfield, 1996).

Mansfield (1996) describes that an organization when seeking a quick and consistent model that defines one set of competencies for a broad range of jobs, may consider the "one-size-fits-all" competency model. A group of jobs is identified and a team is charged with developing a model that is built from other individual job competency models. Typically, it is then reviewed by senior management and revised to be sure it meets the organization's mission and values. Human resource staff then builds applications for use in which to support the model like performance management tools and resource guides. Strengths of this model include the ability to apply one consistent framework that describes behaviors and can be aligned overall with the organization's initiatives to a large number of employees. All employees are assessed against the same competencies, and the model does not need continuous updates every time a job is redefined. The weakness of this model is that it does not clearly describe what is needed in any specific job. Competencies can be seen as values rather than skills needed to

obtain results, and it may not be clear to employees how to apply them to their jobs. This approach usually ignores technical skills and knowledge, which can be important in aligning people to job assignments (Mansfield, 1996).

This job classification approach is sometimes framed in other groups. Rothwell and Linholm (1999) discuss five types of approaches utilized in the U.S. with process-driven and output-driven being typical classics:

- Process-driven approach: the oldest tailored approach typically using the famous Hay/McBer method by attaching weight to the work process that is performed by exemplary job incumbents.

- Output-driven approach: famous from Patricia McLagan and focuses attention on the key outputs of the targeted job, occupation, team, or work group. Outputs are the results of the work from successful performers. Competencies are identified by examining the outputs.

- Invented approach: a fast method low in validity and reliability. Decision makers are guided through a process of making up a competency model, especially when the occupation will be going through changes and is not the best candidate to contribute to the model.

- Trends-driven approach: focuses attention on future issues and places focused attention on what people must know or do in order to respond to their emerging environmental changes.

- Work responsibility approach: derives outputs, competencies, roles, and quality requirements from work responsibilities or activities.

In the U.S. federal government, the United States Office of Personnel

Management (OPM) has conducted job analysis and competency modeling in order to

provide an "empirical foundation for the use of competencies by employees, managers

and human resource in the public sector." This would provide a common based

competency language that would allow federal agencies to describe jobs in the same way

and eliminate inconsistencies across agencies and human resource functions (Rodriguez

et al., 2002; Rothwell & Lindholm, 1999).

Other model considerations. Technical framing as described above in classic

modeling is not the only approach to the development of competency frameworks and

credentialing systems. There are other models and components to consider in competency

models that do affect professions and their stakeholders. Lysaght and Altschuld (1999)

describe different levels of accountability for ongoing competency in the field. One is

self, that is, how the individual judges his or her own competency to determine daily

skills. Another is the consumer who experiences the skill from the practitioner. A third

level is the practitioner's peer standards on what is occurring in the field. The fourth

refers to employers and regulatory agencies where tests and observations are developed

from people in the profession. Another view would be from professional groups, such as

association and licensing boards.

Lysaght and Altschuld (1999) point out that the most effective way to ensure the

maintenance of competency has not been determined, although rival approaches have

been posited. Competency in a profession is the result of commitment and vigilance, and

there are different levels of reliance by the individual, professional peers, professional

certification bodies, and the public. As outlined in Table 2.1 below, Lysaght and

Altschuld (1999) perspectives include the free-market perspective where responsibility is placed on the consumer. It is pointed out that this model is not working well in light of the health care industry where consumers really are powerless to choose providers on many levels. Reliance on disciplinary boards to manage competency deal with large volumes of evidence of incompetency and often problems are never reported. The main reliance now depends on practitioners themselves, but this involves risks such as costs of continuing education, workloads, and other issues restricting professional development.

Table 2.1.

Advantages and Limitations of Competency Evaluation Currently Used in the Professions

Method	Advantages	Limitations
Self-Monitoring	Encourages personal accountability	Lack of objectivity
	Eliminate rating errors based on extrapolation and generalization	Questionable validity of judgments
	Low cost	
Portfolio	Heightens practitioner awareness of competency development needs	Not a direct competency measure
	May enhance knowledge by encouraging reflection on practice and participation in learning	Time consuming for professional
	Low cost to regulatory boards	Requires training for portfolio content to be meaningful
CEUs	Ensures participation in ongoing education by all practitioners	Not a direct competency measure
		Does not ensure transfer of learning or skill to practice
Peer Review	Encourages accountability	Problems with extrapolation and generalization
	May disclose incompetent practice	Difficulties in reaching consensus regarding best practices
		Risk of rater evaluation error
Testing	Greater objectivity than self-assessment	High cost of development
	Can be used as developmental tool	High time requirement
	Potential to identify incompetency based on lapsed knowledge (objective testing) or skills (practical testing)	Historical lack of reliable and valid measures
		Does not often deal with the "Do" component of competency

Note. Taken from "Beyond initial certification: The assessment and maintenance of competency in professions," by Lysaght, R.M. & Altschuld, J.W., 2000, *Evaluation and Program Planning,* 23, p. 100. Copyright 2000 by Elsevier Science Ltd.

The use of subjective judgment by professional associations, as mentioned above, typically involves an iterative series of discussions by decision makers. One type of model is the Delphi Method, originally used as a group technique to bring consensus from a group of experts in one area by using intensive questioning. While the method has evolved since its conception in the 1940s, it is still used today to make valid decisions, especially in areas of social and health sciences (Landeta, 2006). In the case of evaluation competency, self-study by accrediting organizations is a component of the accreditation process in the U.S. Specifically, peer review, site visits, judgment by administrators, and periodic external review are guideline standards that are used (McDavid & Huse, 2015).

An example of applying more than just the classic technical competency model (e.g., job analysis coupled with skill and competency validation methods) to a field is in nursing. In a study analyzing nursing students and their education, it was found that a standard competency model of using job analysis was utilized. However, judgment models through professional and peer review panels are also needed even though they do not hold the same validity. In other words, one size does not fit all especially in fields such as nursing where there is unpredictability and uncertainty in the day-to-day work of the profession (Fordham, 2005).

Competency in public health is complex. Public health alone as a profession does not have a specific credential because it is a mix of professions from across the public health and clinical health system. There are 20 domains and more than 200 competencies that have been identified by the National Public Health Leadership Development Network (NLN) (Grimm, Watanabe-Galloway, Britigan, & Schumaker (2015). Grimm et al. (2015) do not recommend competency-based approaches in evaluating effective health

leadership due to lack of consensus; however, they do recommend identified outcomes expected of roles within public health by implementing customized competency frameworks.

Competency models utilized by employers provide a foundation for employees within their work environment. There are both class models and more tailored models that have been developed. Because of the expansion and contraction of knowledge, skills, abilities, attitudes, tools, and other considerations in regard to competency, it is a complicated undertaking for a profession to decide what competency model to use (Lysaght & Altschuld, 1999). The next section will discuss three theoretical perspectives that provide foundation for this study.

Theoretical Perspectives

Three theories frame this discussion: theory of professionalism, evaluation competency, and signaling theory. The theory of professionalism provides the foundational presentation of how a profession creates itself and the role of credentialing within it, which sets the stage for understanding the rise of professions. Competency, specifically in reference to evaluation and research that has been conducted in coordination with public health, is presented and exists to inform the conceptual framework. Outlined is the historical rise of the medical and public health fields, which provides a comparative sense of where evaluation is in this natural maturity of professions with an overview of where other countries are at with evaluation competency and credentialing. Signaling theory from the labor industry is used for context in this discussion and discusses how education and certification play a signal role to one's qualifications for job potential.

Professionalism. Eliot Freidson (1999), a sociologist who was specifically interested in the rise of medicine and its ethical obligations to society and the overall history of professions, defines professionalism as the "ideology and special set of instructions" in regards to a profession or occupation that "controls its own work, organized by a special set of institutions sustained in part by a particular ideology of expertise and service" (pg.10).

Today's professional activity is not a small affair and the work of expert occupations is typically dominated by large-scale organizations (Evetts, 2011; Muzio & Kirkpatrick, 2011). Organizations have become significant agents in the development of professional identities and modes of regulation. This is not well understood, especially due to constant change and transformation of professions (Muzio & Kirpatrick, 2011). A profession is different ways in which we organize work, workers and relations (Evetts, 2011).

Expertise, credentialism, and autonomy are three dimensions within professionalism. Expertise refers to the idea of one being skilled in a profession rather than being an amateur. It is assumed that most adults with basic skills can learn to drive a vehicle or some similar daily task, but having expertise in something more specific would require taking the time for specialized training. If one could, by a little more training, obtain skills to do a specialized skill and learn the basic fundamentals of a skill, then do we need experts? Freidson (1999) discusses this argument stating that by allowing specialized expertise in a profession, we silo people's skills to one area when they could have the capability of doing other tasks. The opposing view is that there is not enough time in a person's life to learn and understand every subject and task available, some

being extremely specialized and requiring daily practice -- such as performing surgery. This discussion of expertise's magnitude and scope is where Freidson brings us to credentialism, a "protective source of privilege" (Freidson, 1999, 2001).

Freidson (1994) points out that in order for expertise to exist in the environment, it must be institutionalized where there is a conventional way in which people can identify an expert. This would assist the consumer instead of having to rely on word of mouth, experience, and other time and resource-consuming activities that may not work out. He points out that from the consumer view, credentialism is a way to narrow the range of choice and simplify the issue of having to choose some kind of specialist in a world where many exist. It is not a matter of credentialing; it is a question of what kind of knowledge and skill within the occupation and what form it should take.

From the worker's view, Freidson (1994) discusses that credentialism is exclusionary and can lead to inequality. This is because credentialism could exclude the competent and protect the incompetent. A competent worker in a specific field may be able to conduct the work, but lack of a piece of paper excludes the individual from this opportunity. Not only is it impossible for everyone in an occupational role to have the skills of all experts, it is impossible for everyone to have the same kind of expertise. The credentialism criticism is not the fact of selection and exclusion, but whether the basis for exclusion is fair (Freidson, 1994).

The inclusion view of credentialism is that it provides a shelter (Freedman, 1976). Freedman discusses the "shelter" as a device for motivating people to invest time and effort to obtain a particular type of skill. This creates conditions to stay committed to a type of work as opposed to drifting from one occupation to another (Freidson, 1994).

Freidson discusses various types of credentialism and they have important differences. Broad credentialism for a large group of occupations that require education from higher institutions is different than that of the legally obtained and exclusive occupations, such as practicing medicine. Medicine is independent of the institutions in which its members work and has its own specialized training, laws, and standards (Freidson, 1994; Muzio & Kirkpatrick, 2011). Justification of credentialing for other occupations forces us to look at what expertise is so valuable, potentially harmful, complex and/or abstract that labor consumers are unable to choose these workers without some sort of aid for competence and reliability (Freidson, 1994). Jobs overall are becoming more complex due to continuing advancement in technology, legislative changes, and advances in science, and credentialing can help protect those already in jobs (Hale, 2011).

Credentialing also falls into the discussion of professional autonomy, which provides a profession with several dimensions. One dimension is economic where the profession controls training, recruitment, and credentialing. This controls the volume of practitioners, which in turn affects income to the practitioners. There is also a political dimension where the profession is accepted as an authoritative spokesperson for the field's body of knowledge and skill and has influence on administrative and legislative rules that affect its work. "Peer review" in the profession exists as opposed to a hierarchical structure (Freidson, 1994). Beyond formal credentialing, membership in voluntary professional organizations may have restrictions, which leads to a corresponding prestige associated with membership. There can be blurry lines of credentialing related to professional organization where licenses and certifications may

be required as a prerequisite to the organization or the organization offers the option to become licensed or credentialed (Lysaght & Altschuld, 2000; Shackman, 2015).

Freidson (1994) warns that much hostility towards credentialing is due to historic abuse where economic self-interest has outweighed the service. He advises that instead of being caught up in discriminatory opinions of how professions are created, we should be focusing on the advancement of human society. He emphasizes that while many foundational discussions of professionalism lead to the discussion of division of labor and inequality, we should look at the functional differences and what knowledge and skill are valuable to human life (Freidson, 1994). These are important points to consider as a profession is maturing so that as the profession and specialties evolve, they do not create unnecessary disparity.

Evaluation competency. According to Wilcox and King (2013), competence is not the same as having competency. The authors distinguish the two in a recent article addressing evaluation competency in which they explain that competence is an abstract construct that describes the quality of being competent while competency is a concrete concept that has knowledge, skills, and attitudes associated with the quality being qualified (Wilcox & King, 2013). Competency can be measured against accepted standards and improved by training and development (Parry, 1998).

The value of competency in evaluation has existed for quite some time. Weiss (1998), in the second edition of her foundational book about evaluation, explains that evaluation competence ensures confidence in hiring administrators and should take priority. Competencies for evaluation were essentially developed and validated in 1999 (King, Stevahn, Gere, & Minnema) with an updated taxonomy in 2001 (King et al.) and

updated yet again in 2005 (Stevahn, King, Ghere, & Minnema). *The American* Evaluation

Association has not yet formally adopted competencies, but is in the process of

developing a set. These competencies consist of the following domains: professional,

methodology, context, management, and personal (Dr. Jean King, personal

communication, April 9, 2016). In the work by Stevahn et al. (2005), the authors

rationalize why evaluators need the competencies, then revise the list and identify future

needs related to the taxonomy. Stevahn et al. (2005) point out that a practice in

professions such as health care is that once standards are introduced, there is a following

of trainings offered ranging on experience and updates to competencies due to evolving

theory and practice. Evaluation typically has not implemented this practice.

Because competence involves knowledge and skills, it would be remiss not to pay

attention to where evaluators are obtaining some knowledge. Dewey, Montrosse,

Schroter, Sullins, and Mattox (2008) discuss the issue of evaluator competencies

obtained in graduate school and those required and desired by employers. Two surveys

were administered, one is for the job seeker and one for the employer. Results showed

that graduate programs are not providing all of the evaluation skills necessary and that

evaluation-training programs are decreasing. Five major gaps were identified in clusters

of skills taught versus skills sought: interpersonal skills, writing, project and team

management, research design, and evaluation theory.

Davies and Mackay (2014) provide information findings from a survey

administered to university faculty who teach evaluation courses. The survey included

topics taught, time spent on topics, and instructors' perceptions of topic importance. The

study showed there is a lot of diversity in the types of training that evaluation students

receive. Time is an issue, as each discipline does not have time to dedicate in the curriculum all of the evaluation skills needed. Gaps were found in the university training programs. This study provided little evidence that universities target the development of interpersonal skills. Evaluation experience for the student was identified as important but less than half of those surveyed offered the opportunity to students.

Christie, Quinones, and Fierro (2014) conducted a classification study examining an evaluator's coursework training and its relationship to the evaluator's work. The authors point out that little empirical research has been done to describe the aspect of evaluation practice, such as who is conducting evaluation. There are also few existing studies on the evaluator as the unit of analysis regarding how and where trained. The Christie et al. (2014) study was a random sample of American Evaluation Association (AEA) members and results showed that most respondents had completed graduate level methods coursework with less than half taking more specific types of design classes. These courses were taken in university-type settings and often offered in other departments than evaluation. Fewer than 25% of respondents had taken courses in evaluation theory or practice-based courses. If these courses were taken, most were taken in professional development settings. These results led the authors to question how evaluation-specific competencies are being cultivated in the training of current evaluation practitioners.

As mentioned earlier in regard to the public health 10 essential services, the ninth service is "evaluate effectiveness, accessibility, and quality of personal and population-based health services." Like evaluation, public health has core competencies that have been established for its professionals, which have been revised several times over the last

several years as the field advances (Public Health Foundation, 2014b). While it is clear that evaluation is important in public health, little information is available about how evaluation knowledge and skills are obtained by students attending accredited schools or programs of public health (Fierro & Christie, 2011).

A study conducted in 2011 by Fierro and Christie linked how coursework required for attaining a Masters of Public Health degree in epidemiology or health education prepared students to evaluate programs or interventions. Results showed that instructors usually provided lectures on evaluation along with readings, and that health education students received more training than epidemiologists. It was also found that overall, students with a primary focus on program or intervention evaluation that were from the discipline of social and behavioral science were offered evaluation on an annual basis. The study findings appear out of alignment with the required competencies presented to public health professionals. (Fierro & Christie, 2011).

Because evaluation is considering "standardized" evaluator competencies, these standards could assist evaluation in the U.S. in establishing a credential system similar to Canada's. However, the literature is clear that evaluators do not agree on how this should be conducted. Canada has been successful in having their professional evaluation association implement and offer their credential (CES, 2014), similar to public health associations in the United States (APHA, NEHA). Consensus on evaluator competencies and then training of them to other professions could advance a better understanding of what constitutes a knowledgeable evaluator. The next section of signaling theory explains how a potential employee lets a hiring manager know they are competent in skills.

Signaling theory. Signaling theory in the context of job market and economics is a nonverbal communication between employer and potential job applicant. Michael Spence (1973, 2002) explains that applicants present certain signals to employers in order to obtain wages desired. He identifies characteristics like age and gender as "indices" as unalterable characteristics unlike education, which could be a "signal." Signals can be altered by the applicant (he chooses to obtain an education) and/or subject to manipulation (job experience). The employer then takes the chance of hiring the applicant based on their indices and signals that may give clues to the employer about expected output from the worker.

Research on certification signaling in the information technology and automotive industries, conducted by Bartlett (2004), showed that while certification is an important signal, a degree was most ideal. A certificate could be more meaningful if the applicant did not have more than 2 years work experience. Other skills that a certificate would not necessarily demonstrate, such as emotional, social, and intellectual, are also important to hiring managers.

This literature review provided a broad perspective on how public health and evaluation came to be as professions. Public health is a field that has evolved over the years into specific job fields, academic training, and professional licensure for some of it's positions. Evaluation is continuing to evolve as it's professionals build competencies, ethics, and standards. Basic competency models were discussed in order to provide understanding of how professions standardize knowledge in an organizational setting for employees to follow. The theories presented for this paper are professionalism,

evaluation competency, and signaling theory. The next chapter discusses the

methodology used in this research paper.

Chapter 3. Methodology

The purpose of this study was to explore the perceptions and value of evaluator competencies as they relate to the profession of public health. A mixed methods strategy was conducted to address each proposed research question by utilizing a focus group design of public health professionals and an online survey of members of the Minnesota Public Health Association. The research questions, research design, research context, participants, instruments, data collection, and data analysis plan are presented in this chapter.

Research Questions and Design

Two exploratory research questions were addressed through this study in an attempt to develop an understanding of which evaluator competencies are perceived as most important for evaluators of public health programs. More specifically, the two questions were:

1. What are the current perceptions of public health administrators in Minnesota about the skills and expertise of those who conduct evaluations?

2. What do practicing public health professionals view as the most important evaluator competencies for public health evaluators?

The study used a mixed methodology that included multiple focus groups (qualitative) and an online survey (quantitative). Mixed method design includes two or more data gathering and analysis techniques within the same study with the intent to make a connection between the results. Transfer of theory to practice of mixed methods can be complicated and is still being developed (Green, Kreider, & Mayer, 2012). There can be problems with mixed methods, such as judgment of quality of results, due to

different methodological traditions and integration. Another issue can be domination of methodology in regard to design, since methodology prefers to adhere to its traditional guidelines of design (Greene et al., 2012). This practice of mixed method is connecting data, where the analysis of one dataset informs the next data collection and integration occurs when connecting the analysis of results (NIH, 2014).

Three focus groups of six to eight public health professionals were conducted to obtain perspectives on evaluator professionalism in public health. A focus group is more than getting people together to talk. This method is used to gather valuable information by having people share their opinions or experience about a product or service. Patterns of information are collected from groups with similar characteristics in order to assist the researcher in telling the story, in a safe setting that does not judge (Krueger & Casey, 2015; Newcomer, Hatry, & Wholey, 2015).

Ryan, Gandha, Culbertson and Carlson (2014) explained two basic focus group types that they called Type A and Type B. Type A is from an individual social psychology perspective that seeks a person's opinion regarding a program or policy based on an objective managed throughout by the moderator. Type B is freer flowing based on a social constructionist perspective. Stories and memories are sought out and pay attention to who says what and when it is said. Ryan et al. (2014) provide three vignettes for these two focus group types: 1) scoping focus group, a type A group that provides further detail to surveys; 2) theory-building focus group, which is a blend of type A and B and mixes opinions with experiences; and 3) narrative focus group, a type B group where gaps are filled in by knowledge.

Because it is just as important in quantitative methods as qualitative methods to stay within the context of perspective (Harwell, 2011), an online survey was also conducted for this study. Dillman, Smyth and Christian (2014) introduced the survey method of Total Design Method (TDM) in the late 1970s as a system that took the place of older survey methods. The TDM included updated information about how to attract respondents for better response rates with a four-step mailing process and other updated social science information. Dillman et al. (2014) provide an updated survey method called Tailored Design. This design responds to the technology and population changes that affect current survey work and moves from using one design style to designing a survey tailored to the situation and adapted to the use of technology.

The online survey was sent to members of the Minnesota Public Health Association (MPHA) to elicit their view of the most important competencies for public health evaluators. The survey type consisted of purposive sampling because it represented a particular group, not an entire population (Morgan, 2014). This large-scale survey had closed-ended questions developed out of the five CES domains used a 5-point unipolar scale rating. A unipolar scale gradation is when the zero point falls at one of the scale (Dillman et al., 2014). The scale was in range from extremely essential to nonessential in regard to the competencies and their value.

Research Context

The study was conducted in Minnesota (MN). Minnesota has a population of about 5.4 million residents (United States Census Bureau, 2014). In Minnesota, the government public health system consists of a state and local relationship where funds, programs, and services are coordinated, which is typical of the national public health

system in the U.S. (Tulchinsky & Varavikova, 2014). The MN Department of Health (MDH) employs approximately 1,500 public health professionals with an annual budget of approximately $500 million in state, federal, and fee-based funds. The MDH work consists of traditional public health topics such as infectious disease, environmental health, hospital and nursing home regulation, and maternal child health services (MDH, 2012).

Local public health departments in MN are governed either individually or in collaboration with neighboring cities and counties and are called community health boards (CHB). Statewide, there is approximately $20 million in flexible state funding delegated to public health services in communities. Overall, public health departments employ approximately 2,622 public health workers (MDH, 2015).

The MN public health system also includes partnerships with clinical health, non-profit organizations, academia, the private sector, and independent consultants, all of which employ public health professionals who may provide direct service, data collection, academic training, and evaluation. There are several professional public health associations in Minnesota available to public health professionals. The Local Public Health Association (LPHA) is an association that is made up of the local health departments in Minnesota (LPHA, 2016). The Minnesota Environmental Health Association (MEHA) typically caters to environmental health professionals that work in public health (MEHA, 2016). The Minnesota Public Health Association (MPHA) typically is made up of public health professionals from various fields of the public health profession. The MPHA has existed since 1907 and their mission is to create a healthier Minnesota through effective public health practice and engaged citizens (MPHA, 2015).

The MPHA was utilized in this research project because of their broad membership representation and their immediate willingness to assist in this project.

Participants

Subjects for the focus groups were selected from the MN public health field for their experience in public health administration, public policy, and evaluation. This is particularly important for the focus group method because people with characteristics in common provide a more successful discussion (Krueger & Casey, 2015). Three focus groups were conducted over a 2-month period with approximately six to eight members in each. While these focus group subjects were not evaluation experts per se, they were in positions with the authority to review, authorize and/or lead evaluation within the context of public health. Because it has been identified that public health investments are significant and would benefit from standardization, it is important to ask public health experts about how they value evaluator competencies. These key stakeholders of evaluation are context-focused and know how their environment operates regarding political, cultural, and scientific issues as well as how these will affect the final evaluation effectiveness (Patton, 2012).

Subjects for the online survey were from the membership list of the MN Public Health Association (MPHA). At the time of survey administration, there were 403 active members of the MPHA, the majority residing in the Twin Cities area. The MPHA (2015) states that its membership consists of 24% students, 4% retirees, 68% individual memberships, and five organizational memberships (MPHA, 2015). The questions asked were specific to the five evaluator competency domains formally adopted by the Canadian Evaluation Society and used for their Credentialed Evaluator Program. These

domains are: reflective practice, technical practice, situational practice, management

practice, and interpersonal practice (CES, 2010). The survey was sent to all 403

members of the MPHA through their electronic newsletter mailing.

Instrumentation

Focus group method. According to Krueger and Casey (2015), there are five

categories of questions used in focus groups: opening, introductory, and transition

questions, key questions, and ending. These should be used during different times of the

focus group and are organized to the timing of discussion. Opening questions should be

easy to answer and assist people in becoming comfortable with each other. Introductory

questions introduce the topic and assist participants in thinking of their relationship to the

topic. Transition questions move the participant conversation into more depth about the

study. Key questions are the questions intended to get to the point of the study and

should have the most time dedicated to them. Ending questions are the point of closure

and reflections (Krueger & Casey, 2015). In this study, the focus group questions were

open-ended and designed to follow this flow. A first draft of questions was designed and

after review and discussion with Dr. Richard Krueger (personal communication, July 24,

2015), the focus group questions were revised and used to conduct the focus groups.

Survey instrument design. The survey instrument was designed using the

University of Minnesota Qualtrics online survey tool, which is administered through the

Office of Measurement Services. According to Dillman et al. (2014), electronic surveys

that rely on email addresses to make contact and gather responses are the fastest

growing survey type worldwide. The survey questions were designed utilizing the five-

evaluator competency domains formally adopted by the Canadian Evaluation Society

(CES) and in use for their CE program. Each domain then contained their respective competencies with a 5-point unipolar scale to assess the opinion of the competency. A first survey draft consisted of the five domain questions with two unipolar ordinal competency scales ranging from essential to non-essential and a 4-point ranking order of use. The remaining five questions were demographic.

Pretesting is a standard practice in survey development that allows for instrument evaluation and helps identify any problems with language use, layout, and selection options (Dillman et al., 2014; Groves et al., 2009). A content review of the survey was conducted with four public health professionals, all with graduate-level academic credentials. The survey was emailed a week before the meeting with the review team as a sample review of the electronic format for the survey in final form. This review led to an elimination of the 4-point ranking order asking the survey participant if utilizing the competency was necessary. Reviewers stated that by already ranking them as competencies as essential or non-essential would get to this point and that including the second scale only added unnecessary size and length to the survey. Other comments were recorded as to survey appearance and layout, which were adjusted accordingly.

Because content reviewers are not necessarily survey design experts (Dillman et al., 2014; Groves et al., 2009), further review was solicited from a staff person at the Office of Measurement Services at the University of Minnesota. The staff person, an expert in survey design and use of the Qualtrics tool, reviewed the survey design and layout and provided feedback as well as resources on how to best utilize the Qualtrics features for online facilitation.

IRB Process

This study was submitted to the University of Minnesota Institutional Review Board (IRB) for approval prior to any implementation or data collection. The IRB application was accepted with exemption for an IRB review, including the amendment submitted after instrument revision.

Data Collection

For the focus groups, the researcher acted as the moderator with an assistant taking notes, escorting participants to the room, and managing room setup. Each of the three focus groups met over a weekday lunch hour, where a non-monetary incentive of lunch was offered to each participant. The focus group meetings were all held in a conference room in a downtown St. Paul office building with nearby parking available. The first and third focus group contained seven participants, and the second focus group had six. The groups met for 90 minutes with the first 15-20 minutes of the meeting time spent for lunch and introductions. Each participant signed a consent form upon arrival and each group was audio-recorded. The audio recording was then transcribed for the purpose of analysis. Participants were provided with notepads and pens and the room contained a writing pad easel for facilitation notes as needed. A note taker was also present to assist participants and capture key points. A diagram of the seating arrangement was sketched for each focus group session to identify comments by specific group members and to assist with follow-up transcription. Designated time at the end of each discussion was used to go over key points and summarize the discussion.

The survey conducted with the MPHA was solicited through its monthly newsletter. An email was sent out prior to the survey opening, making members aware of

the survey. The non-identifying survey was open for approximately 3 months, with most

survey data responses being collected in the first month of advertisement. The survey

only advertised for 2 out of the 3 months it was open. An incentive was offered at the end

of the survey where participants could enter another link and enter their names in a

drawing for one of two paid renewal memberships to the MPHA. The survey had 135

responders begin the survey, 108 completed the survey, and 83 of the responders entered

their names into the incentive drawing.

Data Analysis

All focus group data that resulted from research question 1 followed the analytic

theme prioritization that Krueger and Casey (2015) suggest: frequency, extensiveness,

intensity, specificity, internal consistency, and perception of importance by the

participant. Information was collected by notes and audio recordings and organized into

themes. The data were then analyzed by a classic analysis strategy which is a manual,

visual, and hands on process. While there are other ways by which to analyze focus group

date, the most important feature is that all focus groups are analyzed consistently

(Krueger & Casey, 2015). Analytic frameworks that exist in which to analyze focus

group data consist of: constant comparative, identifying individual change, critical

incidents, key concepts, and testing alternatives (Krueger & Casey, 2015). A key concept

analytic framework was selected because of the desire to understand how participants

viewed a topic. Themes were then analyzed for each question.

The survey data was coded as ordinal data (rank order) and was non-parametric.

The survey results were received anonymously. The University of Minnesota Qualtrics

survey tool was utilized to manage the survey and descriptive statistics; standard

deviations and mean scores were analyzed and reported. The data were further analyzed in SPSS for descriptive statistics (mean, standard deviation, range, and correlation coefficients) and inferential statistics. Given the ordinal data and the purposive sample, nonparametric statistics were calculated, with the alpha level set at .01 to reduce possible type I error rates. The nonparametric statistics included a Mann-Whitney U test, used to compare whether there are significant differences between respondents with and without supervisory experience. The Kruskal-Wallis test was used to examine whether there was a group difference among public health personnel who were managers, professional, or independent contractors. The survey consisted of closed-ended questions based on the items included in the five Canadian Evaluation Standard domains. A 5-point unipolar scale rating was intended to elicit responses from extremely essential (score value = 5), to somewhat essential (score value = 3), to nonessential (score value = 1).

Summary

The research design for this study was mixed methods consisting of three focus groups of public health administrators (qualitative) and an online survey of MPHA members (quantitative). Instruments for both methods were reviewed prior to implementation. The three focus groups resulted in six to seven participants in each 90-minute focus group meeting. Data were then analyzed utilizing the classic analysis strategy. The 10-question survey used five 5-point unipolar scales of evaluator competency and five demographic questions; the resulting response rate was 28%. The next chapter provides the results from the study.

Chapter 4. Results

This study used a mixed-method approach to address two primary research questions related to public health and evaluator competencies. The first research question inquired into the current perceptions of public health administrators in Minnesota about the skills and expertise of those who conduct evaluations. A focus group method with public health professionals was used for this question, resulting in four key themes. The second research question asked for the views practicing public health professionals held as the most essential evaluator competencies for public health evaluators. This was addressed through an online survey to the members of the Minnesota Public Health Association. The results of each of these methods are presented below. Analysis of the results are discussed in Chapter 5.

Focus Groups

Participants. Three focus groups were conducted, each comprised of six to seven participants (19 total participants). These participants were selected based on their public health experience and roles related to managing agency evaluation contracting plans and employing evaluators. Participants included professionals working in state government, academia, and the non-profit and private sectors. Most participants had similar backgrounds from one employment sector to another. Each of the 19 participants had a minimum of 10 years of professional experience in public health roles, including personnel management, budgeting, legislation, communications, research, human resources, legal, consulting, information technology, planning, nursing, and medicine. Each focus group differed in its representation of each profession with the majority of

members representing government. Participants selected dates offered by the researcher that worked best for them.

Questions for participants. The participants in each focus group were requested to respond to the following questions:

Q1. What is your role in public health and length of time in the field?

Q2. What types of evaluations has your agency or department been responsible for conducting?

Q3. What are the titles for people that conduct evaluations internally?

Q4. What are the titles for people that conduct evaluations externally?

Q5. Before you begin an evaluation project, how do you know if the evaluator is capable or competent? Make a list of competencies on a piece of paper.

Q6. After the evaluation is completed, how can you tell if the evaluator was capable or competent?   Make a list of competencies on a piece of paper.

Q7. If we wanted to cluster these into categories, how might we do it? What clusters do you see?

Q8. Think back to a time when the evaluator you contracted was not performing as expected. What did you observe as their limitations?

Q9. Think back to a time when the evaluator exceeded your expectations. What were the clues that you observed?

Q10. What is the most important competency for evaluators conducting public health evaluations?

Q11. What is the most important idea/issue we've talked about today?

Q12. Is this an adequate summary of what was discussed?

Focus group analysis. A classic analysis (Krueger & Casey, 2015) of the focus group transcripts was conducted. Each focus group was digitally audio recorded and transcribed with personal identifying information redacted from the scripts. The transcribed scripts were then disassembled and arranged in order of the questions asked and further sorted into themes. Theme compilation was conducted in order to identify key concepts with highlighted quotations that stood out and identified what became four key points. Participants in the focus group analysis will be identified as public health professionals (PHP) and to protect privacy, are coded when quoted.

Themes:

- The role of evaluator is not well understood.

- Evaluation is often a responsibility of current staff.

- Consensus on evaluator competencies is limited.

- Evaluators need a balance of interpersonal skills, ethics, and integrity.

Theme 1: The role of evaluator is not well understood. PHPs identified the titles of professionals who are called upon to conduct agency evaluations. Titles varied in response to this question. This could be because roles within public health have different evaluator responsibilities, skill sets, and audiences. State government has predetermined job classifications that are based on knowledge, skills, and abilities which may or may not be part of the same job title. For instance, a planner classification may actually be labeled as a coordinator. Other names in this setting included researcher, epidemiologist, health informaticist, and analyst; these could be either a manager or staff person. One PHP stated that all of their positions conducting evaluation existed in different classifications and listed them as "research scientists, epidemiologists, planners, and a

data manager" (2E). PHPs familiar with testifying to legislators pointed out that titles could be political when placed in front of the legislature for testimony and that "program evaluator doesn't sound like enough; they will want to hear from a research analyst or research scientist" (2B).

By contrast, private sector evaluation consultant groups did identify with the evaluator title. Sometimes evaluation work went beyond individual help and consisted of a team. PHPs from a non-profit and academia setting explained: "Evaluation teams exist that are made up of the evaluator coordinator, but include physicians, nurses, social workers, and health care consultants" (1F & 3B). It was identified that evaluation work could be a component of a specific public health position. PHPs intimately familiar with local public settings stated, "They don't typically have public health evaluators, but the role may actually be incorporated job duties for the public health nurse or public health planner" (1G & 3E).

The title of evaluator was reportedly not only generic, but also flexible. PHPs working in the private sector as evaluators of public health programs call the evaluation what the client wants it to be called and described it like this: "Sometimes we may call them needs assessments or environmental scans. It doesn't really matter to the client what term is used" (3C & 3D). The title of evaluator is not sufficiently specific to the needs of these public health professionals. Evaluators perform a number of functions or tasks that are easier to understand and communicate if they are identified by specific task, such as needs assessment, environmental scan, cost-benefit analysis, or formative evaluation.

PHPs working in the government sector used the term *legislative proposals* and *return on investments* as an evaluation type because of the typical legislative inquiry of

program purpose. PHPs working in internal agency supported roles for public health such as communications and human resources observed their evaluation models differently. For example, a PHP in communications described his/her experience as "less formal and more qualitative with regard to messaging and its success" (2A).

   Theme 2: Evaluation is often a responsibility of current staff. The tasks performed by evaluators are not distinct or unique from that of other public health employees. To these PHPs, the tasks performed by evaluators are also those that are done by a variety of other professionals. Evaluation responsibilities are embedded in a variety of other public health jobs. PHPs described that titles of who the evaluator is in the public health setting could vary. It could either be a position or a part of one's job duties. One PHP described it as "one of the challenges of public health and program evaluators, it is not often that you find peer program evaluators. It is an embedded skill that is within what someone does and if you do find a program evaluator, it is most likely an external evaluator that would come in and provide that specific service" (1G).

   The person reporting on evaluation results to an audience may not be the individual who actually conducted it. It was discussed among all three groups that management level people may have certain skill sets needed in their job that differ from program experts or people conducting the evaluation. One PHP explained it as "upper management are the communicators, the ones that have to go out and talk which is different from evaluators and the work they are doing and that somehow there needs to be translation between the two" (2E). This participant explained further:

   > People from different types of settings may be better at communicating results than others. You can have a brilliant person who is a great methodologist, understands the content, but, if they can't communicate it back and then problem

solve, they would just utterly fail in a political setting because it does not operate in a perfect controlled environment (2E).

Theme 3: Consensus on evaluator competencies is limited. There was considerable discussion among each of the focus groups regarding what constitutes a competency, which might differ from a skill, and whether these were learned traits or innate to the individual. All three groups identified two basic categories of what they thought were competencies and the titles of the two groups varied, although one PHP pointed out "there are layers of competencies" (1G). One competency categorization was organized into technical or facilitation skills that could probably be taught. This included education, methods, interviewing, and writing. The other grouping had names like soft skills or innate (inherent in the person) skills. This included items from the list like honesty and reflective listening. One PHP reacted to the term *soft skill* by questioning its meaning because "it sounded less important than technical skills, which are equally important" (3C).

All PHP participants had in-depth discussions about the idea that no single trait could occur successfully without the other because they complemented each other. As one PHP described, "Public health is science-based and needs the scientific methods, but also needs to bridge with qualitative and participative in order to be real" (3E). There was consensus among two groups that the importance of a competency could depend on the role within the organization. For instance, "an entry level evaluator may be newly trained in technical skills, but be someone more experienced at interpersonal skills" (1G).

Based on their own judgment, PHPs listed the following as important traits for evaluators of public health programs and made attempts to categorize them (Table 4.1).

Table 4.1.

Identified Traits of Importance for Evaluators of Public Health Programs From Focus Group Respondents

Technical	Non-Technical
Presentation skills	Past performance references
Writing	Effective communicator
Negotiation	Follows logic
Analytical	Thinks outside the box
Data collection skills	Curious/interested
Methodological skills	Unique content experience
Project management	Understands big picture and details
Facilitation skills	Ability to work with diverse stakeholders
Interprets data	Emotional intelligence
Interviewing	Creativity
	Reflective listening
	Honesty
	Critical thinking

Theme 4: Evaluators need a balance of interpersonal skills, ethics, and

integrity. It was very important to the PHPs that evaluators of public health programs

understand how to work with others and have an internal integrity to their work. One

PHP described this as "an evaluator understanding best practices and community wisdom

and balancing this in terms of their evaluation work" (3C). The ability to tell the

evaluation story that balanced science, stakeholders' beliefs and opinions, and brought all

traits to the evaluation was discussed as an overall successful evaluation. Another PHP

described this concept as "the challenge for public health to take an individual's story and

make it big enough to change policy and behavior on a global level" (3E). One PHP

described this issue:

> There are many evaluations that go forward and produce really beautiful glossy
> reports that are complete fluff. They get away with it because the audience is not

educated enough and because they produce these really pretty 50-page graphic report, and everyone's like flip-flip-flip, oh look a quote with a pretty kid" (3D).

When PHPs discussed what clues in past public health evaluations by evaluators exceeded exceeded expectations, understanding the big picture and communications were listed. When PHPs discussed what clues in past public health evaluations by evaluators did not exceed expectations, lack of understanding people, the environment or how to use specific traits were mentioned the most. One PHP described an incident where "an evaluator had excellent technical skills but was lacking in interpersonal skills, resulting in problems" (1E).

Summary. Three focus groups were conducted comprised of Minnesota public health professionals. Participants came from public and private sectors as well as non-profit settings with experience and education from various public health professions. The purpose was to answer the research question: What are the current perceptions of public health administrators in Minnesota on the skills and expertise of those who conduct evaluations? When these public health professionals talked about evaluation competencies, they stressed the following several points. Evaluator is a generic role that is not well understood in terms of the skills and competencies it should include. Within public health the concept of evaluation encompasses many different tasks and the skills needed for the evaluation will vary by task. As a result, the title of "evaluator" is often lacking in precision. Evaluation is a function that may be performed by a variety of different individuals with various job titles. Internal public health employees with a range of titles are regularly called upon to conduct evaluation tasks. Across the three focus groups, views differed widely regarding the competencies associated with the role of evaluator. There was, however, general agreement that the cluster of skills can fit into

broad categories such as "technical skills" and "soft skills." Overall, evaluation competency is reportedly the balancing of technical expertise with practicality, community wisdom, and social skills.

Survey

An online survey was conducted to address the following research question: "What do practicing public health professionals view as the most essential evaluator competencies for evaluators conducting evaluations of public health programs?"

Survey respondents. The survey was sent to the entire MPHA membership (N = 403). Completed surveys were received from 108 MPHA members representing a 28% response rate. For confidentiality reasons, the MPHA only allowed direct marketing of the survey through its monthly newsletter, where the members could then self-select to take the survey. Because of this, there were not opportunities for follow up to further promote the survey.

Because participants constituted a "purposive" sample, rather than a random sample from Minnesota's total public health professional population, findings from this study cannot generalize beyond those responding to this survey. The MPHA membership does, however, include a broad representation of professionals working in a variety of public health settings. As shown in Table 4.2, of the 108 total respondents for the survey, 34% held upper management or appointed level positions in a public health setting, 51% held staff positions, and 16% were independent contractors. Sixty-eight percent of the respondents did not have experience supervising evaluators. Most respondents came from state and county government agencies, public health clinics, and other non-profit health services programs; there were also a number of professionals identifying as independent

contractors. The majority of respondents had more than 11 years of public health experience.

Table 4.2.

Role in Public Health Setting

Role	n	Percent
Appointed position	6	6%
Management	30	28%
Staff	55	51%
Independent contractor	17	16%
Total	108	100%

Supervisory experience in relation to the competency domain ratings. Means and standard deviations were calculated for each competency domain. The mean results illustrate that respondents rated all competencies "strongly essential" to "extremely essential", which is a 5 and 4 on the ordinal scale of the survey. The data in Table 4.3 show that all competency domains were highly valued whether the respondent had supervised evaluators in the past or not. In examining the means and standard deviations, some modest variability is found in the management practice domain by those with supervisory experience having the highest standard deviation of $SD = .63$. For those with no supervisory experience in the situational practice domain, the highest standard deviation is $SD = .63$.

Table 4.3.

Comparing Respondents With and Without Supervisory Experience in Relation to the Five Competency Domains of the Canadian Evaluation Society

	Supervisor Experience			No Supervisor Experience		
	M	*SD*	*n*	*M*	*SD*	*n*
Reflective Practice	4.58	.40	35	4.49	.40	73
Technical Practice	4.46	.44	34	4.50	.38	71
Situational Practice	4.28	.53	35	4.17	.63	72
Management Practice	4.25	.63	34	4.30	.60	72
Interpersonal Practice	4.44	.61	34	4.46	.57	72

Role in public health setting in relation to the competency domain ratings. The means and standard deviations for the five competency domains in relation to the public health role are reported in Table 4.4 Similar to the findings in Table 4.3, the means were uniformly rated as "strongly essential" to "extremely essential" irrespective of role delineation. Some variability is noted for the group identified as professional staff for the situational practice domain with the highest standard deviation of $SD = .67$.

Table 4.4.

Comparing Respondents' Role in Public Health Settings in Relation to the Five Competency Domains of the Canadian Evaluation Society

	*Management			Professional Staff			Independent Contractor		
	M	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*
Reflective Practice	4.56	.36	35	4.45	.45	55	4.67	.28	17
Technical Practice	4.56	.31	34	4.43	.45	54	4.52	.37	16
Situational Practice	4.18	.56	35	4.16	.67	55	4.39	.42	17
Management Practice	4.32	.61	35	4.22	.63	54	4.40	.55	17
Interpersonal Practice	4.41	.57	34	4.40	.63	54	4.68	.39	17

*Note. *Appointed and management positions combined.*

Correlational analysis. The Spearman rank correlation coefficients computed to understand the strength and direction of the linear relationship among the five competency domains for those with and without supervisory experience. Table 4.5 shows the correlation coefficients for each group; correlations appear strong among all of the competency domains for those with supervisory experience. The strongest correlation appears between the situational practice and reflective practice domains, where $r = .802$, $p < .01$. This is a strong positive correlation, demonstrating that these respondents rated both domains as "extremely essential." The weakest correlation occurs between interpersonal practice and technical practice ($r = .353$, $p = <.096$) and technical practice and reflective practice ($r = .366$, $p = <.033$).

Strong relationships are also illustrated in Table 4.5 for those who do not have direct experience supervising evaluators. The strongest correlation exists between

management practice and situational practice ($r = .752, p < .01$). Table 4.5 shows all p values $< .01$, indicating a strong correlation between all domain competency rankings from those who do not have evaluator supervision experience.

Table 4.5.

Correlation Between Competency Domains With Supervisory Experience

	Reflective	Technical	Situational	Management	Interpersonal
Reflective					
Technical	.366**				
Situational	.802**	.463**			
Management	.514**	.412*	.703**		
Interpersonal	.572**	.353*	.712**	.566**	

*Note. * p < .05. ** p < 01*

Correlation Between Competency Domains Without Supervisory Experience

	Reflective	Technical	Situational	Management	Interpersonal
Reflective					
Technical	.499**				
Situational	.623**	.554**			
Management	.514**	.654**	.752**		
Interpersonal	.646**	.448**	.677**	.587**	

*Note. * p < .05. ** p < 01*

Spearman correlations were also computed to understand the strength and direction of the linear relationship between the five competency domains in relation to the professional roles of the survey respondents (appointed position or management, professional staff, and independent contractor). Again, a strong positive relationship is

found among all domains (see Table 4.6). For the group identified as appointed position

or managerial, the strongest correlation was between management practice and situational

practice, where $r = .778, p < .01$. This means that the respondents held consistent views

of these competencies as being "strongly" to "extremely" essential. Some variability is

noted in Table 4.6; however, all tests were significant and positively correlated,

illustrating a common perception of the competency domains. The group identified as

professional also reported a strong, positive correlation in relation to the five domains.

The strongest relationship was between management practice and situational practice,

where $r = .716, p < .01$. Overall, the professional group illustrated the strongest

relationship between each of the five competency domains.

Table 4.6 also includes the responses from the group identified as "independent

contractor," which indicated some variability in responses. The strongest relationship was

between management practice and situational practice, where $r = .743, p < .01$. Several

correlations, however, were found not to be significant. The weakest relationship

appeared to exist between interpersonal practice and management practice, where $r =$

$.244, p = < .345$ indicating the somewhat limited relationship between these domains for

this group. The relationship between interpersonal practice and technical practice is also

weak, where $r = .252, p = < .346$. There is limited understanding to account for this

variation; however, it is important to note that the group identified as independent

contractor was small (individual cells for analysis ranged from 12 to17). Modest

differences in item ratings may have resulted in additional variability.

Table 4.6.

Correlation Between Competency Domains and Roles in Public Health Settings (Appointed or Management)

	Reflective	Technical	Situational	Management	Interpersonal
Reflective					
Technical	.408[*]				
Situational	.753[**]	.444[**]			
Management	.491[**]	.471[**]	.761[**]		
Interpersonal	.600[**]	.228	.758[**]	.596[**]	

Correlation Between Competency Domains and Roles in Public Health settings (Professional Staff)

	Reflective	Technical	Situational	Management	Interpersonal
Reflective					
Technical	.509[**]				
Situational	.635[**]	.575[**]			
Management	.525[**]	.692[**]	.716[**]		
Interpersonal	.626[**]	.564[**]	.686[**]	.688[**]	

Correlation Between Competency Domains and Roles in Public Health Settings (Independent Contractors)

	Reflective	Technical	Situational	Management	Interpersonal
Reflective					
Technical	.573[*]				
Situational	.735[**]	.405			
Management	.486[*]	.504[*]	.743[**]		
Interpersonal	.594[*]	.252	.553[*]	.244	

Note. $* p < .05. ** p < 01$

Mann-Whitney U test. The Mann-Whitney U test is a non-parametric test used

with a sample that is not representative of the general population (Siegel, 1956). It is used

for ordinal measurement and tests the difference between two independent groups that

have been drawn from the sample (Siegel, 1956). The Mann-Whitney U test for this study

illustrated that there was no significant difference among respondents with and without

supervisory experience in reflective practice (U = 1082.50, Z = -1.29, p =.196), technical

practice (U = 1167.5, Z= -271, p = .786), situational practice (U = 1164.5, Z = -.636, p

=.786), management practice (U = 1175.5, Z = -.330, p =.741), and interpersonal practice

(U = 1180.0, Z = -.301, p =.763). In other words, the two groups were similar in their

ratings of the competencies.

Kruskal-Wallis test. The Kruskal-Wallis one-way analysis of variance test is

useful in finding whether there are actual differences in the sampled population or

whether they represent a chance variation that is expected in a random sample from the

same population (Siegel, 1956). The Kruskal-Wallis test is also a nonparametric test that

extends the Mann-Whitney U test when there are more than two subgroups. This test was

used to examine whether there was a group difference among public health personnel

who were managers, professionals, or independent contractors. A Kruskal-Wallis test for

this survey data showed that there were no significant differences among managers,

professional staff, or independent contractors in their ratings regarding reflective practice

(χ^2 = 3.55, d.f. = 2, p=.170), technical practice (χ^2 = 1.39, d.f. = 2, p =.500), situational

practice (χ^2 = 1.48, p =.477), management practice (χ^2 = 1.17, d.f. = 2, p =.558), and

interpersonal practice (χ^2 = 3.52, d.f. = 2, p =.712). These results indicate that the

respondents by role: manager, professional staff, or independent contractor and tended to rate these items very similarly.

Summary

This chapter summarized the results of the methods used for each of the two research questions. For the question of current perceptions of public health administrators in Minnesota on the skills and expertise of those who conduct evaluations, three focus groups were conducted over a 3-month time frame with four key themes emerging. For the question concerning practicing public health professionals' views about the most important evaluator competencies for public health evaluators, an online survey was sent to 403 members of the Minnesota Public Health Association, and resulted in a 28% response rate. Respondents were asked to rank how essential they perceived the competency domains of the Canadian Evaluation Standards. Survey results showed that most respondents, no matter what the supervisory experience or role, rated the competencies as "strongly" to "extremely" essential with limited variability in item responses across the five competency domains. Chapter 5 will discuss these results in relation to their implications for public health agency practice and offer recommendations for further research.

Chapter 5. Analysis and Recommendations

Introduction

Public health is a profession that continues to evolve to meet complex societal and cultural needs of the general public. Because of this, professions in the public health field (e.g., nursing, public health workers, sanitarians) have matured into specific job positions that require specialized knowledge, skills, and competencies.   Professional accreditation, certification, and/or licensure are well established and accepted aspects of the public health field. These professional credentials are used to signify an understood level of skills and competencies among professionals and commonly used as minimum standards for entry into various professions. Because public health programs are complex and expensive to implement, effective evaluations of its programs and services are important. Currently, there is not an evaluation "specialty" position that resides in the public health field. There is also the additional challenge for state, county, and local public health agencies when they attempt to contract for evaluation services. That is, without a clear understanding of evaluator competencies, public health agency administrators may make poor choices in contracting individuals to undertake evaluations of their policies, programs, and/or services.

Evaluation is a professional field that is continuing to evolve. Evaluators typically are broadly trained in various methodologies and skills and work within a broad set of public and private contexts. Worldwide, there are various sets of competencies and accreditations that exist in which to demonstrate specialty in the profession. The European Evaluation Society (EES) recently developed their evaluation capabilities framework. The purpose of this framework is to raise awareness of the competencies

needed by professional evaluators to conduct quality evaluations (EES, 2015). The

Australasian Evaluation Society (AES) has developed ethical guidelines for evaluation

(Wilcox & King, 2014), and more recently has released a professional learning

competency framework that identifies the competencies needed by evaluators (AES,

2013). Canada has also adopted competencies and established a formal evaluator

credentialing program. These competencies and competency domains were used as the

basis of this study's online survey.

The interest in establishing credentials for evaluators was caused by issues

plaguing the evaluation community, such as lack of evaluation credibility due to

underfunding, poor evaluation quality, and evaluators wanting a professional identity

(Kuji-Shikatani, 2015). The Canadian competencies domains and their subgroups are

adaptations of the Stevahn et al. (2005) previously discussed. The competency domains

are:

1. Reflective Practice: focus on the fundamental norms and values underlying
   evaluation practice and awareness of one's evaluation expertise and needs for
   growth.

2. Technical Practice: focus on the specialized aspects of evaluation, such as design,
   data collection, analysis, interpretation, and reporting.

3. Situational Practice: focus on the application of evaluative thinking in analyzing
   and attending to the unique interests, issues, and contextual circumstances in
   which evaluation skills are being applied.

4. Management Practice: focus on the process of managing a project/evaluation,
   such as budgeting, coordinating resources, and supervising.

5. Interpersonal Practice: focus on people skills, such as communication,
   negotiation, conflict resolution, collaboration, and diversity (Canadian Evaluation
   Society, 2014).

In the United States, there is still discussion about whether or not to establish a

professional evaluator certification or other credential as a means of verifying the

essential competencies needed for undertaking evaluations (American Evaluation Association, 2016).

The purpose of this study was to explore the perceptions held by public health professionals regarding the competencies conceivably needed by professional evaluators. As mentioned throughout this paper, the U.S. has not yet formally adopted evaluation competencies; however, the American Evaluation Association's Evaluator Competency Task Force is in the process of revising the current set of competencies (personal communication from Dr. Jean King, April 9, 2016). Because public health is increasingly being required to conduct evaluations of its programs and services to assess relative levels of service effectiveness, quality, and costs (including return on investment), it is important to investigate what is currently understood regarding these competencies in terms of the knowledge and awareness public health professionals hold in relation to the importance and value of these competencies. Evaluations in public health are typically outsourced to contracted evaluators (including public and private evaluation agencies and firms) or are conducted within the agency by existing public health agency staff. As noted in this study, evaluation tended to be an additional responsibility assigned to existing staff and typically included within a staff member's job description. Therefore, not only is there a concern over making good decisions regarding the contracting of evaluators, there is the additional concern as to who, within the public health agency, is best suited to conduct an evaluation in terms of their knowledge, skills and competencies. If not adequately addressed, there are obvious implications for public health agencies in terms of potentially conducting poorly designed evaluations that in turn lead to erroneous and misleading results and conclusions.

Chapter 4 provided the analysis of the focus groups and the online survey of public health professionals. Several key themes were identified from the focus groups demonstrating public health professionals' views on evaluator competencies. Survey data illustrate a high level of agreement by survey respondents on their ratings of competency essentials. Based on the analysis of the survey data, all competencies and competency domains were rated as "extremely essential" to "strongly essential." Data also illustrated a strong positive correlation across the five competency domains regardless of evaluator supervisory experience or specific professional role (i.e., appointed position/managerial, professional staff, or independent contractor). Further, when analyzing within group differences based on supervisory experience or professional job role, statistical differences were found. In this chapter, the results of the study will be discussed and the implications of these findings for public health practice and future research will be presented.

Findings and Interpretations

Research question 1: Qualitative themes. Research question 1 requested respondents to address the following broad, overarching question: "What do practicing public health professionals view as the most essential evaluator competencies for public health evaluators?" For this question, three focus groups consisting of public health administrators in Minnesota were conducted. Each focus group differed somewhat in terms of its membership, however, the majority represented government agency professionals with more than a decade of public health career experience. The participants were requested to convey their views and perspectives regarding evaluator knowledge, skill, and competencies in relation to a series of questions. They were asked

to (1) share positive and negative experiences in working with evaluators; (2) identify factors that contributed to these experiences; (3) discuss challenges in contracting evaluators; and (4) identify competencies that evaluators should minimally possess. Four key themes were identified: (1) the role of evaluator is not well understood; (2) evaluation is often a responsibility of current staff; (3) consensus on evaluator competencies is limited; and (4) evaluators need a balance of interpersonal skills, ethics, and integrity. These themes and their importance are further discussed.

Theme 1: The role of evaluator is not well understood. Public health professionals who participated in the focus groups concurred that the professional title of "evaluator" does not necessarily convey a clear understanding of what a professional in this role does, what knowledge and skills they possess, nor what professional training, background, and experience are associated with calling oneself an evaluator. In the public health field professional roles such as physician, nurse, sanitarian, and so forth are well defined and understood as a trained profession. There are many traditional public health job titles, such as nurses and health educators, that could be conducting evaluation tasks. This theme is important to understand because it is not uncommon for public health professionals to have evaluation responsibilities as part of their job role along with the specialized knowledge and skills required in their public health positions (Tulchinsky & Varavikova, 2014).

Government agency participants also agreed that the term "evaluation" is too broad, encompassing many different methods and approaches, including cost-benefit analysis, needs assessments, program evaluation, and environmental scans. Private sector representatives felt an evaluation could be titled anything the customer wanted it to be as

long as the final product reflected an answer to the question posed by the client. All of this depends on the purpose and goals for the evaluation that is needed. Weiss (1998) explains why context is important and presents varying reasons as to why an evaluation is conducted, thus possibly explaining the varied evaluation titles from focus group participants. Evaluations could be conducted simply as a grant requirement fulfillment (Weiss, 1998), which is often called a "program assessment" by public health professionals. Weiss also identifies public relations as a reason to conduct evaluations, where visibility of a highly successful program is beneficial to powerful stakeholders. Cost-benefit analysis is this type of evaluation, as identified by focus group participants, that would be provided to state legislators or professional boards to support funding. It is clear that the terms *evaluator* and *evaluation* can hold different meanings for those who work in the public health field.

   Theme 2: Evaluation is often a responsibility of current staff. As discussed in Theme 1, the terms evaluator and evaluation are not seen as a clearly defined or a distinct role in public health. The focus groups' consensus was that evaluation is far more viewed as being embedded within current positions rather than existing as a singular public health position classification. Evaluation knowledge, skills, and responsibilities are instead viewed as part of many professional classifications.

   As mentioned earlier, those who represented government in public health for the focus groups listed many different types of jobs in public health in which evaluation was a component. These jobs included research scientist, planner, data managers, and public health nurses, not unlike the public health workforce list presented by Tulchinsky and Varavikova (2014).

Chapter 2 references the five types of competency models presented by Rothwell and Linholm (1999); one of these is the Hay method, a process driven approach in which weight is attached to the process that is performed. In Minnesota state government, the Hay method is currently used to classify positions, including those in public health, however, a public health evaluation job classification does not exist (Minnesota Management and Budget, 2016). The role of evaluator also has not clearly established itself as a unique, independent professional role within the public health field based on the views of the focus group participants. Because of this, it is not unusual that participants pointed out the issue of evaluation as an embedded job task instead of a specific position within the public health field.

Theme 3: Consensus on evaluator competencies is limited. Based on the questions asked of the focus group participants for this study, they identified the most important knowledge, skills, and competencies an evaluator should have for public health programs. This information was then organized into two broad categories, technical and non-technical (see Chapter 4, Table 4.1). There was considerable discussion and lack of consensus among focus group members regarding this list of technical and non-technical competencies and skills.

It is not uncommon to experience disagreement regarding the competencies associated with specific professional roles. While the public health field is an advanced profession, as pointed out in Chapter 1, there is still little consensus about which competencies are most valuable in specific professional roles. Grimm et al. (2015) illustrate the lack of agreement with the 20 domains and over 200 competencies named in public health. Similarly, even when the evaluation practice in the U.S. has developed

competencies, there is no uniform consensus on their adoption (Stevahn et al., 2005). It is clear that specific competencies are important, but not which competencies are the most important in evaluations of public health programs and services.

   Theme 4: Evaluators need a balance of interpersonal skills, ethics, and integrity. Focus group participants agreed that evaluators should be individuals with strong interpersonal skills with high integrity and ethical standards. Weiss (1998, pp. 320-326) dedicates a full chapter in her book, *Evaluating with Integrity,* to topics such as balance, judgment, and ethics. These are identified by others in the evaluation field in various contexts (Altschuld & Engle, 2015; King & Stevahn, 2015; Morris, 2008). Basic evaluation texts teach that these are critical to the success of evaluation. In the *Handbook of Practical Program Evaluation*, the authors state that ethical challenges can be common in evaluation work due to the politics and variability of sources that guide the evaluation (Hatry, Newcomer, & Wholey, 2015). The American Evaluation Association (AEA), through input of its members, has developed five guiding principles for evaluators that are evolving, and that are interrelated with a focus on self-examination. The AEA guiding principle of integrity and honesty states that evaluators should display honesty and integrity in their own behavior, and ensure the honesty and integrity of the entire evaluation process (AEA, 2004). The focus groups highly valued these competencies and traits and noted that these principles should serve as a guide when seeking out evaluation services.

   The focus group participants discussed how competencies are obtained and whether they are innate or taught. Davies and Mackay (2014) discuss this issue in their survey of evaluation courses at a university where little evidence was found that

programs are teaching these skills to students. Given that public health programs are primarily social service programs, it is important that public health professionals agree with those who have developed the basics of the evaluation profession.

Summary. The focus group methodology was used to ask the research question of what do practicing public health professionals view as the most essential evaluator competencies for public health evaluators. While the terms *evaluator* and *evaluation* are used in public health, there is still a wide range of views on what these terms mean concerning the knowledge, skills, and competencies evaluators need to possess. Further, an "evaluator" is currently not a specialized role, but rather embedded into one of the many already specialized positions in the public health field. Public and private sectors may manage these titles differently depending on their settings. All focus group participants concurred that ethics and integrity were important to the evaluation field.

Research Question 2: Competency essentiality results. An online survey of public health professionals was conducted to address the question "What do practicing public health professionals view as the most important evaluator competencies for public health evaluators?" Survey responses were analyzed to identify differences among (1) respondents with and without direct supervisory experience in contracting and working with evaluators and (2) whether the ratings of how essential a competency was perceived varied as a function of professional role (i.e., appointed/managerial, professional staff, or independent contractor). An online survey was conducted with members of the Minnesota Public Health Association. Members who responded to this survey were primarily government staff level positions with no supervisory experience of evaluators. The survey consisted of closed-ended questions based on the items included in the five

Canadian Evaluation Standard domains adopted by the Canadian Evaluation Society

(CES) used in their evaluation credentialing program. The scale range of opinion went

from "extremely essential" to "non-essential." These domains are: reflective practice,

technical practice, situational practice, management practice, and interpersonal practice

(CES, 2010). Each domain is defined and consists of subgroups as seen in Table 5.1.

Table 5.1.

*Competencies and Competency Domains from the Canadian Evaluation Soc*iety

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Reflective Practice: the fundamental norms and values underlying evaluation practice and awareness of one's evaluation expertise and needs for growth.
- Applies professional evaluation standards
- Acts ethically and strives for integrity and honesty
- Respects all stakeholders
- Considers human rights and the public welfare in evaluation practice
- Provides independent and impartial perspective
- Aware of self as an evaluator (knowledge, skills, dispositions) and reflects on personal evaluation practice (competencies and areas for growth)
- Pursues professional networks and self development to enhance evaluation practice

Technical Practice: the specialized aspects of evaluation, such as design, data collection, analysis, interpretation, and reporting.
- Understands the knowledge base of evaluation (theories, models, types, etc.)
- Specifies program theory
- Determines the purpose for the evaluation
- Determines ability to evaluate program
- Frames evaluation questions
- Develops evaluation designs
- Defines evaluation methods
- Identifies data sources
- Develops reliable and valid measures/tools
- Collects data
- Assesses validity, reliability and trustworthiness of data
- Analyzes and interprets data
- Draws conclusions and makes recommendations
- Reports evaluation findings and results

Situational Practice: the application of evaluative thinking in analyzing and attending to

the unique interests, issues, and contextual circumstances in which evaluation skills are being applied.

- Respects the uniqueness of the site
- Examines organizational, political, community and social contexts
- Identifies impacted stakeholders
- Identifies the interests of all stakeholders
- Serves the information needs of intended users
- Attends to issues of evaluation use
- Attends to issues of organizational and environmental change
- Applies evaluation competencies to organization and program measurement challenges
- Shares evaluation expertise

Management Practice: the process of managing a project / evaluation, such as budgeting, coordinating resources and supervising.

- Defines work parameters, plans and agreements
- Attends to issues of evaluation feasibility
- Identifies required resources (human, financial and physical)
- Monitors resources (human, financial and physical)
- Coordinates and supervises others
- Reports on progress and results
- Identifies and mitigates problems/issues

Interpersonal Practice: focus on people skills, e.g., communication, negotiation)

- Uses written communication skills and technologies
- Uses verbal communication skills
- Uses listening skills
- Uses negotiation skills
- Uses conflict resolution skills
- Uses facilitation skills (group work)
- Uses interpersonal skills (individual and teams)
- Uses collaboration / partnering skills
- Attends to issues of diversity and culture
- Demonstrates professional credibility

Note. Table developed from Canadian Evaluation Society's Competencies for Canadian Evaluators: Canadian Evaluation Society (2014). Professional Designations Program. Retrieved August 11, 2014 from http://evaluationcanada.ca/site.cgi?s=50&ss=1&_lang=en

Competency domain ratings: Supervision and role position in public health.

The survey data were used to ascertain whether there was a difference in responses between those with supervisory experience of evaluators versus those without. This was important to consider because it could be assumed that those with supervisory experience would have a more clear and informed understanding of the role of the evaluator and the competencies needed than those having no prior supervisory experience. It was also of interest to assess whether the public health role (i.e., appointed or managerial, professional staff, or independent contractor) led to different responses in terms of competency essentiality. Mean scores examining both supervisory experience and role resulted in a high ranking of importance for all of the competency domains no matter the supervisory experience or role in public health.

Strong, positive correlations were uniformly found in all analyses. In other words, all respondents rated the competencies either "extremely essential" or "strongly essential" with little variance throughout the survey data. These results were not unlike the challenges experienced by focus group participants in trying to prioritize evaluator competencies and traits. The survey findings continued to represent the challenge of trying to rank one competency as more important than another for an evaluator.

The data analysis showed strong, positive correlations between public health survey respondents with and without supervisory experience in relation to the five domains and their competencies. For those who had experience supervising evaluators, the strongest correlation appeared between the Situational Practice and Reflective Practice domains. For those who did not have experience supervising evaluators, the strongest correlation existed between Management Practice and Situational Practice. This

may be because supervisors of evaluators have a priority for management competencies that differs from staff, who do not have this responsibility. It is not a surprise that different roles would prioritize these domains differently based on their own interests and experiences.

   Analysis of differences based on supervisory experience and professional role. Non-parametric tests were conducted to determine if there were significant differences between the individual competency domains and respondents' survey ratings of the competencies. These tests indicated that there were no significant differences between respondents with and without supervisory experience across all five domains. Similar results were found among managerial, professional staff, or independent contractors in their ratings of the domains. This again could reflect the fact that there was limited variance in the rankings of importance of all of the competencies and competency domains.

   Summary. Survey methodology was used to inquire about Research Question 2, that is, what public health professionals in Minnesota feel are the most important competencies for evaluators. Members of the Minnesota Public Health Association were respondents in order to represent the public health workforce in Minnesota. Survey results show that in general there was little variance in the results; the respondents ranked the majority of the competency domains as "extremely essential" or "strongly essential" with little variation regardless of supervisor experience and role.

Limitations of the Study

Mixed method studies typically benefit from a research design that assigns logic to the method conducted. Two main principles are applied: prioritizing, which means there is a core method and then a supplementary method. The other is sequencing, where methods are conducted in an order (Morgan, 2014). Inquiry for this study was conducted at the same time whereas the survey was open during the time the focus groups were conducted. This is a limitation because if the focus groups were conducted first, perhaps their results could have resulted changes in the survey that may have led to different results. Perhaps if the survey were conducted first, it could have elevated different questions to the focus groups.

The focus group part of the study captured information from public health administrators from various levels of administration and public and private sectors in Minnesota. It cannot be assumed that these views represent the entire public health workforce. Barbour and Schostak (2011) point out that the use of focus groups, while economical and convenient, can also have limitations, such as the verbal context converted into writing and possibly interpreted incorrectly by the researcher. The authors point out that social position could also be an issue within the focus group social arrangement in which some members may hold different positions of power. This could lead to apprehension by some in the group in giving honest answers to focus group questions. This relationship may have existed with some of the participants while unknown to the researcher.

There are four types of survey errors that may affect survey quality: coverage error, sampling error, nonresponse error, and measurement error. Coverage error is when

the list from the sample frame does not accurately represent those being sampled. The survey sample frame conducted for this study was limited to the members of the MPHA, thus minimizing coverage error within the sample frame (Dillman et al., 2014). Sampling error, where only some of the sample units within the sample frame are sampled, was avoided due to all of the MPHA members being invited to the survey. Nonresponse error, which is when some of the respondents within the sample frame respond and some do not, was intended to be minimized by advertising and invitation. The survey invitation and ongoing marketing was conducted by the MPHA based on the need to keep their members' personal information confidential. While Dillman et al. (2014) recommend personalizing individual email messages to the potential survey respondent, the communications for this survey were sporadic and only through newsletters when the MPHA volunteers were able to facilitate them. Another limiting factor of this survey was that respondents were self-selected. Out of 403 MPHA members, 135 responded to the survey, resulting in a 28% response rate, and 108 completed the survey, resulting in an 80% completion rate. Measurement error is due to poor question design that leads to inaccuracy in respondents' answers (Dillman et al., 2014). This was addressed earlier in the instrument section when describing question content and survey expert review.

Because the researcher for this paper is a public health expert in Minnesota, unintended bias could exist in selection of participant selection, question design, and data interpretation.

Recommendations and Conclusions

Implications for public health practice. As presented throughout this dissertation, public health programs are complex and increasingly high-cost so that

appropriate evaluations are needed in order to demonstrate their effectiveness or help improve their function. The evaluation profession acknowledges this challenge and need for increased levels of competency among professional evaluators. The *Handbook of Practical Program Evaluation* includes the following statement (Hatry, Newcomer, & Wholey, 2015):

> The environment in which managers and evaluators work is becoming even more challenging. However, the increasing need to justify expenditures with results and the push for evidence-based policy provide opportunities for expanding evaluation efforts. Taxpayers and legislators will likely be even more insistent on economy, efficiency, and identifying what they are are receiving for their money. This will continue to encourage pubic officials at federal, state and local levels, and others providing funding or using public funds, to justify their funding with some form of evaluation information. (p. 829)

This study explored the perceptions of the value of evaluator competencies through the lens of public health professionals in Minnesota. Overall, the competencies were viewed as "extremely essential" to "non-essential," irrespective of respondents' supervisory experience or professional role. There is a need to: (1) consider how these competencies can be utilized by public health agencies in guiding their decisions in contracting evaluators and (2) use these competencies as a framework or foundation for continuing and professional development programs for current agency staff.

Regarding the first point, public health staff who prepare requests for proposals (RFPs) and/or establish proposal review criteria used in selecting prospective evaluation contractors could apply these competencies. For example, selected competencies could readily be included in these processes to formally request contract applicants or bidders to respond in their applications regarding their experience or the ways in which they possess these competencies. Further, application review teams could also use selected competencies in reviewing applications for funding.

The competencies can also serve as a useful framework from which continuing education and professional development programs can be developed. While formal university training is important, on-the-job training in specific topics and competency themes may be more effective (Hatry, Newcomer, & Wholey, 2015). Many of the decisions to contract evaluators are made by current public health staff with little or no formal training on evaluation methods and practices. Conducting professional development programs specifically on these competencies appears to be an important consideration in the field of public health. Government agencies in Minnesota, where the Hay method is utilized to develop position descriptions that public health, could add evaluator competency awareness as a component of basic required knowledge and skills. This would build in a basic requirement of foundational evaluation competency awareness, signaling to potential applicants the desire for this knowledge in the public health profession.

Future discussion may also be warranted to establish a formal position title of evaluator within, at the very least, the state public health agency. This would provide more clarity as to who is actually conducting evaluations and would provide an opportunity for a position dedicated to the public health evaluation work. It would require obtaining valuable evaluator competencies as part of established knowledge and skills. As previously stated, public health is comfortable with licensing and/or credentialing of their profession, however, whether one specific to public health evaluation would be beneficial also needs further inquiry.

Implications for evaluation. As discussed throughout this paper, the evaluation profession continues to mature and hold discussions as to how best to advance its

practice. While this study was set in the public health context of evaluation, it was not a study of evaluation context specifically. There is discussion in the evaluation field as to how context is important for evaluators with broad evaluation skills when they are working on a context specific topic (King & Stevahn, 2015). This topic is mentioned in basic evaluation handbooks as well (Newcomer, Haley & Wholey, 2015; Patton, 2012; Weiss, 1998). More study is needed in this area, to find out the value of having specific context competency and whether this makes an evaluation more useful.

Implications for research. The findings of this study have several implications for future research. It would be of interest to use alternative methods to rate competencies to further discriminate their relative importance. In this study, virtually all the competencies were rated as "extremely" to "strongly" essential. This finding, while useful in confirming the value and importance of these competencies, does not provide further needed distinctions. A forced ranking of individual competencies and domains from high to low may be useful to have respondents further discriminate their views on the competencies. A case study model may also be useful for this inquiry of individuals in public health agencies. More in-depth information might be obtained from a study of the primary decision makers in contracting evaluators who could identify their reasoning and rationale for hiring and what competencies they expect the evaluators to have.

Summary

The purpose of this study was to inquire about what public health professionals in Minnesota feel are the most important evaluator competencies. Public health is an established profession that deals with complex and expensive social programs. It has been identified in this study that Minnesota public health professionals felt that all

evaluator competency domains, specifically those adopted by the Canadian Evaluation

Society, are essential to the evaluator in order to produce a substantive evaluation

product. While this new information is helpful to the evaluation literature in

understanding what users of evaluation feel is important, it begs further questioning about

why all competencies considered essential with little variance. It is not viable to think

that one person must obtain and be well skilled in every competency in order to conduct

effective evaluations. Both public health and evaluation professions have an equal ethical

responsibility of refining competency requirements to ensure that evaluations are

conducted with rigor, professionalism, and responsibility. This will help ensure that

recipients of complex public programs are being assisted with quality services.

References

Altschuld, J. W. (1999). The case for a voluntary system for credentialing evaluators. *American Journal of Evaluation*, *20*(3), 507-517.

Altschuld, J. W. (2005). Certification, credentialing, licensure, competencies, and the like: Issues confronting the field of evaluation. *Canadian Journal of Program Evaluation*, *20*(2), 157-168.

Altschuld, J.W., & Engle, M. (2015). The inexorable historical press of the developing evaluation profession. In J.W. Altschuld & M. Engle (Eds.), *Accreditation, certification, and credentialing: Relevant concerns for U.S evaluators. New Directions for Evaluation, 145*, 5-19.

American Evaluation Association. (2004). *Guiding Principles for Evaluators.* Retrieved April 9th, 2016 from http://www.eval.org/p/cm/ld/fid=51.

Australasian Evaluation Society. (2013). *Evaluators' Professional Learning Competency Framework.* Retrieved April 10th, 2016 from http://aes.asn.au/professional-learning/pl-resources.html

Barbour, R.S. & Schostak, J. (2011). Interviewing and focus groups. In B. Somekh & C. Lewin (Eds.), *Theory and methods in social research* (2nd ed.). (pp. 61-68). New Delhi, India: Sage Publications.

Bartlett, K. R. (2004). The Signaling Power of Occupational Certification in the Automobile Service and Information Technology Industries. *National Dissemination Center for Career and Technical Education*. Columbus, OH: The National Research Center for Career and Technical Education.

Barry, J. M. (2004). *The Great Influenza: The epic story of the deadliest plague in history.* New York, NY: Penguin.

Black, B.P. (2014). *Professional nursing: Concepts and challenges* (7th ed*.).* St. Louis, MO: Elsevier Saunders.

Buchanan, H., & Kuji-Shikatani, K. (2014). Evaluator competencies: The Canadian experience*. The Canadian Journal of Program Evaluation, 28*(3), 29-47.

Burwell, S. M., Munoz, C., Holdren, J., & Krueger, A. (2013). Memorandum for the Heads of Executive Departments and Agencies: Next Steps in the Evidence and Innovation Agenda. Retrieved from http://www.whitehouse.gov/sites/default/files/omb/memoranda/2013/m-13-17.pdf.

Canadian Evaluation Society (2014). *Professional Designations Program*. Retrieved
August 11, 2014 from http://evaluationcanada.ca/site.cgi?s=50&ss=1&_lang=en

Centers for Disease Control & Prevention. (1999). Framework for program
evaluation in Public Health. *MMWR Morb Mortal Wkly Rep*, 48(No.
RR-11).

Centers for Disease Control & Prevention, Program Performance and Evaluation
Office. (2012). *Introduction to Program Evaluation for Public Health Programs:
A Self-Study Guide. Step 1: Engage Stakeholders*. Retrieved January 16th, 2016
from http://www.cdc.gov/eval/guide/step1/index.htm

Centers for Disease Control & Prevention. (2014). *The Public Health System and the 10
Essential Public Health Services*. Retrieved August 23, 2014 from
http://www.cdc.gov/nphpsp/essentialservices.html

Chadderton, C. & Torrance, H. (2011). Case Study. In B. Somekh & C. Lewin (Eds.),
Theory and methods in social research (2nd ed.). (pp. 53-60). New Delhi, India:
Sage Publications.

Christie, C. A., Quinones, P., & Fierro, L. (2014). Informing the discussion on evaluator
training: A look at evaluators' course taking and professional practice. *American
Journal of Evaluation, 35*(2), 274-290. doi: 10.1177/1098214013503697

Davies, R., & MacKay, K. (2014). Evaluator Training Content and Topic Valuation in
University Evaluation Courses. *American Journal of Evaluation*, *35*(3), 419-429.

Dewey, J.D., Montrosse, B.E., Schroter, D.C., Sullins, C.D. & Mattox II, J.R. (2008).
What's taught versus what's sought. *American Journal of Evaluation*, *29*(3),
268-287. doi: 10.1177/1098214008321152

Dillman, D.A., Smyth, J.D. & Christian, L.M. (2014). *Internet, phone, mail and mixed-
mode surveys. The tailored design method* (4th ed.). Hoboken, NJ: John Wiley &
Sons.

Duffy, J. (1992). *The Sanitarians: A history of American public health*. Chicago, IL:
University of Illinois Press.

Evetts, J. (2011). A new professionalism? Challenges and opportunities. *Current
Sociology*, *59*(4), 406-422.

European Evaluation Society. (2015). *The EES Evaluation Capabilities Framework*.
Retrieved April 10th, 2016 from http://europeanevaluation.org

Fierro, L. A., & Christie, C.A. (2011). Understanding evaluation training in schools and programs of public health. *American Journal of Evaluation, 32*(3), 448-468. doi: 10.1177/1098214010393721

Fink, A. (2013). *Evidence-based public health practice.* Thousand Oaks, CA: Sage Publications.

Fitzpatrick, J. L., Sanders, J.R., & Worthen, B. R. (2011). *Program evaluation: Alternative approaches and practical guidelines (Fourth ed.)*. Upper Saddle River, New Jersey: Pearson Education, Inc.

Food Inspection. (1926). *American Journal of Public Health,* 16(2), 157-159. doi: 10.2105/AJPH.16.2.157

Fordham, A. J. (2005). Using a competency based approach in nurse education. *Nursing Standard*, *19*(31), 41-48.

Freedman, M. K., & Maclachlan, G. (1976). *Labor markets: segments and shelters.* New York: Allanheld, Osmun & Co.

Freidson, E. (1988). *Profession of medicine: A study of the sociology of applied knowledge.* Chicago, IL: University of Chicago Press.

Freidson, E. (1994). *Professionalism reborn: Theory, prophecy and policy.* Cambridge, UK: Polity Press.

Freidson, E. (2001). *Professionalism, The third logic: On the practice of knowledge.* Chicago, IL: The University of Chicago Press.

Gauthier, B., Kishchuk, N., Borys, S., & Roy, S.N. (2014). *The CES Professional Designations Program: Views from CES Members.* Paper presented at the CES Conference, Ottawa, June 16, 2014.

Gilliam, W. S., & Zigler E.F. (2001). A critical meta-analysis of all evaluations of state-funded preschool from 1977 to 1998: Implications for policy, service delivery and program evaluation. *Early Childhood Research Quarterly*, *15*(4), 441-473.

Government Accountability Office. (2003). Youth illicit drug use prevention: DARE long-term evaluations and federal efforts to identify effective programs. Washington, D.C.: U.S. Government Printing Office.

Government Accountability Office. (2013). Program evaluation: Strategies to facilitate agencies' use of evaluation in program management and policy making. Washington, D.C.: U.S. Government Printing Office.

Green, J.C., Kreider, H. & Mayer, E. (2012). Combining qualitative and quantitative methods in social inquiry. In B. Somekh & C. Lewin (Eds.), *Theory and methods in social research, 2nd Ed.* (pp. 259-266). New Delhi, India: Sage Publications.

Greenberg, B. G. (1958). Committee on evaluation and standards. *American Journal of Public Health and the Nations Health*, *48(*6), 779-781.

Grimm, B.L., Watanabe-Galloway, S., Britigan, D.H. & Schumaker, A.M. (2015). A qualitative analysis to determine the domains and skills necessary to lead in public health. *Journal of Leadership Studies*, *8*(4), 19-26.

Groves, R.M., Fowler, F.J., Couper, M.P., Lepkowski, J.M., Singer, E., & Touranger, R. (2009). *Survey methodology* (2nd Ed.). Hoboken, N.J.: John Wiley & Sons.

Hague, E. W. J. (1928). The importance of proper training for sanitary inspectors. *American Journal of Public Health and the Nations Health, 18*(8), 1010-1017.

Hale, J. (2011). *Performance-based certification: How to design a valid, defensible, cost-effective program.* San Francisco, CA: John Wiley & Sons.

Harris, M. J. (2010). *Evaluating public and community health programs.* Hoboken, New Jersey: Jossey-Bass.

Harwell, M. R. (2011). Research design in qualitative/quantitative/mixed methods. In C.F. Conrad & R.C. Serlin (Eds.), *Research in education* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Hatry, H.P., Newcomer, K.E. & Wholey, J.S. (2015). Evaluation challenges, issues, and trends. In Newcomer, K.E., Hatry, H.P. & Wholey, J.S. (Eds.), *Handbook of practical program evaluation* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Health and Human Services (2014). Prevention and public health fund. Retrieved March 8, 2015, from http://www.hhs.gov/open/prevention/index.html

Irwin, K., Ballard, J., Grendon, J., & Kobayashi, J. (1989). Results of routine restaurant inspections can predict outbreaks of foodborne illness: The Seattle-King County experience. *American Journal of Public Health, 79*(5), 586-590.

Jacob, S. & Boisvert, Y. (2010). To be or not to be a profession: Pros, cons and challenges for evaluation. *Evaluation, 16*(4). doi: 10.1177/1356389010380001

Japan Evaluation Society (JES). (2016). Retrieved February 6th, 2016 from http://evaluationjp.org/english/index.html

King, J.A., & Stevahn, L. (2015). Competencies for program evaluators in light of adaptive action: What? So what? Now what? In J.W. Altschuld & M. Engle (Eds.), *Accreditation, certification, and credentialing: Relevant concerns for U.S. evaluators. New Directions for Evaluation, 145*, 21-37.

King, J. A., Stevahn, L., Ghere, G., & Minnema, J. (1999). Essential evaluator competencies. *Minneapolis, MN: University of Minnesota, Program Evaluation Studies.*

King, J. A., Stevahn, L., Ghere, G., & Minnema, J. (2001). Toward a taxonomy of essential evaluator competencies. *American Journal of Evaluation, 22*(2), 229-247.

Koehler, G. (1919). Food inspection and food in relation to public health. *American Journal of Public Health*, *9*(6), 418-426.

Kochanski, J. T. (1996). Introduction to special issue on human resource competencies. *Human Resource Management*, *35*(1), 3-6.

Koppes, L. L. Ed. (2014). *Historical perspectives in industrial and organizational psychology*. New York: Psychology Press.

Krueger, R. A., & Casey, M. A. (2015). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage publications.

Kuji-Shikatani, K. (2015). Credentialed evaluator designation program, the Canadian experience. In J.W. Altschuld & M. Engle (Eds.), *Accreditation, certification, and credentialing: Relevant concerns for U.S. evaluators. New Directions for Evaluation, 145*, 71-85.

Lachance, C. R., Burrus, B. B., & Richmond, A. (2012). Building an evidence base to inform interventions for pregnant and parenting adolescents: A call for rigorous evaluation. *American Journal of Public Health*, *102*(10), 1826-1832.

Landeta, J. (2006). Current validity of the Delphi method in social sciences. *Technological Forecasting and Social Change, 73*(5), 467-482.

Leung, C. W., Cluggish, S., Villamor, E., Catalano, P. J., Willett, W. C., & Rimm, E. B. (2014). Few changes in food security and dietary intake from short-term participation in the supplemental nutrition assistance program among low-income Massachusetts adults. *Journal of Nutrition Education and Behavior*, *46*(1), 68-74.

Local Public Health Association of Minnesota. (2016). Retrieved from http://www.lpha-mn.org.

Lysaght, R. M., & Altschuld, J.W. (2000). Beyond initial certification: The assessment and maintenance of competency in professions. *Evaluation and Program Planning*, *23*, 95 -104.

Mansfield, R. S. (1996). Building competency models: Approaches for HR professionals. *Human Resource Management*, *35*(1), 7-18.

McDavid, J.C., & Huse, I. (2015). How does accreditation fit into the picture? In J.W. Altschuld & M. Engle (Eds.), *Accreditation, certification, and credentialing: Relevant concerns for U.S. evaluators. New Directions for Evaluation, 145*, 53-69.

Minnesota Department of Health. (2012). *Minnesota Department of Health Overview* Retrieved from http://www.health.state.mn.us/divs/opa/MDHoverview20120401.pdf

Minnesota Department of Health. (2015). *Workforce Summary for Minnesota's Community Health Services System in 2014*. Retrieved from http://www.health.state.mn.us/ppmrs/library/docs/2014_staffing.pdf

Minnesota Environmental Health Association (MEHA). (2016). Retrieved from https://mehaonline.org

Minnesota Management and Budget. (2016). *Hay Evaluation*. Retrieved from http://mn.gov/mmb/employee-relations/classification-and-job-evaluation/hay_evaluation/

Minnesota Public Health Association. (2015). *2014/2015 MPHA Annual Report*. Retrieved from http://www.mpha.net/Resources/Documents/2014-15%20MPHA%20Annual%20Report%20FINAL%202%202015.05.26.pdf

Morgan, David L. (2014). *Integrating qualitative and quantitative methods, a pragmatic approach*. Thousand Oaks, CA: Sage.

Morris, M. (2008). *Evaluation ethics for best practice*. The Guilford Press: New York, NY.

Muzio, D., & Kirkpatrick, I. (2011). Introduction: professions and organizations - a conceptual framework. *Current Sociology*, *59*(4), 389-405.

National Environmental Health Association. (2014). Retrieved August 10, 2014, from http://www.neha.org/credential/index.shtml

National Institute of Health. (2014). Retrieved August 24, 2014, from http://obssr.od.nih.gov/scientific_areas/methodology/mixed_methods_research/section2.a   spx

Newcomer, K.E., Hatry, H.P. & Wholey, J.S. (2015). *Handbook of practical program evaluation* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Ogden, A. D. (1953). Training and utilization of sanitary inspectors in the United Kingdom. *American Journal of Public Health, 43*(12), 1507-1513.

Orszag, P. (2009). *Memorandum for the Heads of Executive Departments and Agencies: Increased Emphasis on Program Evaluations.* Retrieved from http://www.whitehouse.gov/sites/default/files/omb/assets/memoranda_2010/m10 -01.pdf.

Orszag, P. R. (2010). *Memorandum for the heads of executive departments and agencies: Evaluating programs for efficacy and cost-efficiency.* Retrieved from http://www.whitehouse.gov/sites/default/files/omb/memoranda/2010/m10-32.pdf.

Parry, S. B. (1998). Just what is a competency? (And why should you care?). *Training, 35*(6), 58.

Patton, M.Q. (2012*). Essential of utilization-focused evaluation.* Thousand Oaks, CA: Sage.

Podems, D., Goldman, I., & Jacob, C. (2014) Evaluator competencies: The South African government experience. *The Canadian Journal of Program Evaluation*, *28*(3), 71-85.

Public Health Foundation. (2014a). *What is Public Health?* Retrieved August 22, 2014 from http://www.cdcfoundation.org/content/what-public-health

Public Health Foundation. (2014b). *About the Core Competencies for Public Health Professionals.* Retrieved August 10, 2014 from http://www.phf.org/programs/corecompetencies/Pages/About_the_Core_Compet encies_f or_Public_Health_Professionals.aspx

Rodriguez, D., Patel, R., Bright, A., Gregory, D., & Gowing, M.K. (2002). Developing competency models to promote integrated human resource practices. *Human Resource Management*, *41*(3), 309-324.

Rog, D. J. (2012). When background becomes foreground: Toward context-sensitive eval-uation practice. In D. J. Rog, J. L. Fitzpatrick, & R. F. Conner (Eds.), *Context: A frame-work for its influence on evaluation practice. New Directions for Evaluation*, *135*, 25–40.

Rothwell, W.J., & Lindholm, J.E. (1999). Competency identification, modeling and assessment in the USA. *International Journal of Training and Development, 3*(2).

Ryan, K. E., Gandha, T., Culbertson, M.J., & Carlson, C. (2014). Focus group evidence: Implications for design and analysis. *American Journal of Evaluation, 35*(3), 328-345.

Seidling, M.B. (2015). Evaluation certification and credential revisited: A survey of American Evaluation Association members in the United State. In J.W. Altschuld & M. Engle (Eds.), *Accreditation, certification, and credentialing: Relevant concerns for U.S. evaluators. New Directions for Evaluation, 145*, 87-102.

Shackman, G. (2015). Accreditation, certification, credentialing: Does it help? In J.W. Altschuld & M. Engle (Eds.), *Accreditation, certification, and credentialing: Relevant concerns for U.S. evaluators. New Directions for Evaluation, 145*, 103-113.

Siegel, S. (1956). Non parametric statistics. Series in psychology. New York: McGraw Hill.

Spence, M. (1973). Job market signaling. *The Quarterly Journal of Economics*, *87*(3), 355-374.

Spence, M. (2002). Signaling in retrospect and the informational structure of markets. *The American Economic Review*, *92*(3), 434-459.

Stevahn, L., King, J. A., Ghere, G., & Minnema, J. (2005). Establishing essential competencies for program evaluators. *American Journal of Evaluation*, *26*(1), 43-59. doi: 10.1177/1098214004273180

Tulchinsky, T. & Varavikova, E. (2014). *The New Public Health* (3rd ed.). San Diego, CA: Elsevier, Academic Press.

Ustedt, J. T., Epstein, D. J., & Barnett, W. S. (2013). Early childhood education programs in the public schools. *Handbook of Research on the Education of Young Children* (3rd ed.). New York: Routledge.

Unites States Census Bureau. (2015). Retrieved February 2, 2016, from http://quickfacts.census.gov/qfd/states/27000.html

United States Department of Health & Human Services. (2014). Retrieved March 8, 2015, from http://www.hhs.gov/open/prevention/index.html

Vo, A.T. & Christie, C.A. (2015). Advancing research on evaluation through the study of context. In Paul R. Brandon (Ed.), *Research on Evaluation. New Directions for Evaluation, 148*, 43-55.

Wehipeihana, N., Bailey, R., Davidson, E. J., & McKegg, K. (2014). Evaluator competencies: The Aotearoa New Zealand experience. *Canadian Journal of Program Evaluation*, *28*(3).

Weiss, C.H. (1998). *Evaluation.* Upper Saddle River, NJ: Prentice-Hall, Inc.

Wholey, J.S. (2015). Use of evaluation in government. In Newcomer, K.E., Hatry, H.P. & Wholey, J.S. (Eds.), *Handbook of practical program evaluation* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Wilcox, Y., & King, J.A. (2013). A professional grounding and history of the development and formal use of evaluator competencies. *The Canadian Journal of Program Evaluation*, *28*(3), 1-28).

Worthen, B. R. (1999). Critical challenges confronting certification of evaluators. *American Journal of Evaluation*, *20*(3), 533-555.

Appendix A

Focus Group Consent Form
for
Dissertation Research
University of MN, College of Education
Organizational Leadership and Policy Development
Doctoral Candidate: Michelle Larson

Study: Perspectives on Evaluator Professionalism in Public Health

What is the research?
You have been asked to take part in a research study that is being conducted by Michelle Larson, Doctoral Candidate at the University of Minnesota. This study will be used to complete the doctoral requirements for the research component of the curriculum. This information will also be beneficial to the evaluation field and public health field.

Why have I been asked to take part?
You have been invited to participate because you have public health level management experience that may include hiring evaluators, overseeing evaluated program and using results.

Voluntary participation
This discussion is voluntary and you do not have to take part if you do not want to. This project is not related to any national, state or local organization including the Minnesota Department of Health. If you do not take part, it will have no effect on services provided to by any agencies or organization. You may leave the group at any time and you are not obligated to answer any questions.

Risks and Benefits
There are no known risks involved in taking part of this focus group study. There are no personal risks or benefits. Your insights could be helpful to researches as they seek insights to this topic area.

Audio Recording
This discussion will be audio recorded to ensure that comments are accurately captured. Your privacy will be protected and your name will not be used in any report. This discussion will be kept strictly confidential and this recording will only be available to the moderator and assistant moderator. The recordings will be stored securely and erased when the analysis is completed.

If you agree to this consent form, please check yes and sign
_____ Yes, I agree to take part in the focus group study.

Name _____

Signature _____

Date _____

Focus Group Template

Name of Study: Perspectives on Evaluator Professionalism in Public Health
Date:
Time: 11:30 -1:00
Location: St. Paul MN
Type of Participants: Public Health Professional
Number of Participants:
Moderator Name: Michelle Larson
Moderator Assistant:
Seating Arrangement Diagram:

<u>Agenda</u>

Sign In
Sign Off Consent Form
Table Tent
Lunch Pick Up

Welcome: *Good afternoon and welcome. Thank you for taking the time to join our discussion of perspectives on evaluator professionalism in public health. My name is Michelle Larson and I am a public health professional and also a doctoral candidate at the U of MN. You are assisting me in the required research work that will assist me in completing my doctoral requirements. Assisting me today is Alix Noonan, a colleague and friend.*

Overview of the topic: *The problem I am addressing in my dissertation work is that while complex community based health programs, services, and interventions can be challenging and expensive to evaluate, there is a critical need to ensure that professional's possess the essential competencies needed to engage in high quality and technically sound evaluations of these programs and services.*
As a high level public health professional, you were invited because you have expertise in overseeing some type of work in public health and are in a position to make decisions on staffing and budgeting in your role. I want to tap into your experiences and knowledge about public health workers and competency.

Ground Rules: *There are no wrong answers and I expect different points of view. Please share your view even if it differs from others.*
We are recording the session because we don't want to miss any comments. No names will be included in reports. Any comments will be presented in a summarized format.
Don't feel like you have to respond all the time. If you want to follow up on something that someone said, agree, disagree, give an example, etc. please do this. Have conversations. The table is turned here and I will not be lecturing but encouraging you to provide information and ideas.
If you have a cell phone, please put on quiet and step out if you need to take a call.

Definitions:
Evaluation: a task those who do it might be called evaluators or they might be called other things. There are a variety of job titles. But within their responsibilities they perform evaluation. they may be internal or external. They may be part time or full time.

What is an evaluator?
  •   It is a person (or a team) who plans, conducts and reports on an evaluation.
  •   It could be an outside consultant or an internal employee
  •   It could be part-time or full time.
  •   It could be a job responsibility that is given to an employee
  •   The job title could vary, such as: (in public health) evaluator and researcher. It
  may be embedded in other existing positions.

What do these people do?
These people plan and conduct evaluations. They gather, collect, assemble and analyze data that
is used to make decisions relating to the overall program. These evaluation efforts have a variety
of labels, such as:
  •   needs assessment
  •   logic models
  •   program evaluations (product evaluations)
  •   process evaluations
  •   formative evaluations
  •   summative evaluations
  •   participatory evaluations
  •   legislative auditors
  •   program audits
  •   program reviews
  •   market research
  •   other titles?
Note that we are not including personnel evaluation, drug trials, product evaluations or fiscal
audits.

Questions:
  Q1. What is your name, role in public health, and length of time in the field?

  Q2. What types of evaluations has your agency or department been responsible for
  conducting?

  Q3. Let's first talk about internal people. What are the titles these people have?

  Q4. What are the titles for the external people?

  Q5. Before you begin an evaluation project, how do you know if the evaluator is capable
  or competent? Make a list of them of competencies on a piece of paper.

  Q6. After the evaluation is completed, how can you tell if the evaluator was capable or
  competent?   Make a list of competencies on a piece of paper.

  Q7. If we wanted to cluster these into categories, how might we do it? What clusters do
  you see?

  Q8. Think back to a time when the evaluator was not capable or competent. What were
  the clues that you observed?

  Q9. Think back to a time when the evaluator exceeded your expectations. What were the
  clues that you observed?

Q10. What is the most important competency for evaluators conducting public health evaluations?

Q11. What is the most important thing we've talked about today?

Q12. Is this an adequate summary of what was discussed?

Thank you very much for your time today. Please contact me if you have questions or concerns or wish to follow up on anything.

Appendix C

Public Health Evaluator Competency Survey

This survey is confidential and your information is not available to the researcher. All information is coded through Qualtrics as non-identifiable and will be used for dissertation research purposes only. If you have questions or concerns about this survey, please contact Michelle Larson at lars1805@umn.edu.

Q1 Reflective Practice is the use of the fundamental norms and values underlying evaluation practice and awareness of one's evaluation expertise and needs for growth. Do you find this

competency essential for public health evaluators and would you want your evaluator of public health programs to use this competency?

	Extremely Essential (5)	Strongly Essential (4)	Moderately Essential (3)	Slightly Essential (2)	Nonessential (1)
Applies professional evaluation standards (1)	O	O	O	O	O
Acts ethically and strives for integrity and honesty (2)	O	O	O	O	O
Respects all stakeholders (3)	O	O	O	O	O
Considers human rights and the public welfare in evaluation practice (4)	O	O	O	O	O
Provides independent and impartial perspective (5)	O	O	O	O	O
Aware of self as an evaluator and reflects on personal evaluation practice (6)	O	O	O	O	O
Pursues professional networks and self development to enhance evaluation practice (7)	O	O	O	O	O

Q2 Technical Practice is the specialized needs of evaluation such as design, data collection, analysis, interpretation, and reporting. Do you find this competency essential for public health evaluators and would you want your evaluator of public health programs to use this competency?

	Extremely Essential (5)	Strongly Essential (4)	Moderately Essential (3)	Slightly Essential (2)	Nonessential (1)
Understands the knowledge base of evaluation (theories, types, methods, and tools) (1)	○	○	○	○	○
Specifies program theory (2)	○	○	○	○	○
Determines the purpose of the evaluation (3)	○	○	○	○	○
Determines program evaluability (4)	○	○	○	○	○
Frames evaluation questions (5)	○	○	○	○	○
Develops evaluation designs (6)	○	○	○	○	○
Defines evaluation methods (qualitative, quantitative or mixed) (7)	○	○	○	○	○
Identifies data sources (8)	○	○	○	○	○
Develops reliable data measures/tools (9)	○	○	○	○	○
Collects data (10)	○	○	○	○	○
Assesses validity, reliability and trustworthiness of data (11)	○	○	○	○	○
Analyzes and interprets data (12)	○	○	○	○	○

Draws conclusions and makes recommendations (13)	○	○	○	○	○
Reports evaluation findings and results (14)	○	○	○	○	○

Q3 Situational Practice is the application of evaluative thinking in analyzing and attending to the unique interests, issues and contextual circumstances in which evaluation skills are being

applied. Do you find this competency essential for public health evaluators and would you want your evaluator of public health programs to use this competency?

	Extremely Essential (5)	Strongly Essential (4)	Moderately Essential (3)	Slightly Essential (2)	Nonessential (1)
Respects the uniqueness of the site (1)	○	○	○	○	○
Examines organizational, political, community and social contexts (2)	○	○	○	○	○
Identifies impacted stakeholders (3)	○	○	○	○	○
Identifies the interest of all stakeholders (4)	○	○	○	○	○
Serves the information needs of the intended stakeholders (5)	○	○	○	○	○
Attends to issues of evaluation use (6)	○	○	○	○	○
Attends to issues of organizational and environmental change (7)	○	○	○	○	○
Applies evaluation competencies to organization and program measurement challenges (8)	○	○	○	○	○
Shares evaluation expertise (9)	○	○	○	○	○

Q4 Management Practice is the process of managing a project / evaluation such as budgeting, coordinating resources and supervising. Do you find this competency essential for public health evaluators and would you want your evaluator of public health programs to use this competency?

	Extremely Essential (5)	Strongly Essential (4)	Moderately Essential (3)	Slightly Essential (2)	Nonessential (1)
Defines work parameters, plans and agreements (1)	○	○	○	○	○
Attends to issues of evaluation feasibility (2)	○	○	○	○	○
Identifies required resources (human, financial, physical) (3)	○	○	○	○	○
Monitors resources (human, financial, physical) (4)	○	○	○	○	○
Coordinates and supervises others (5)	○	○	○	○	○
Reports on progress and results (6)	○	○	○	○	○
Identifies and mitigates problems / issues (7)	○	○	○	○	○

Q5 Interpersonal Practice are people skills, such as communication, negotiation, conflict resolution, collaboration, and diversity. Do you find this competency essential for public health evaluators and would you want your evaluator of public health programs to use this competency?

	Extremely Essential (5)	Strongly Essential (4)	Moderately Essential (3)	Slightly Essential (2)	Nonessential (1)
Uses written communication skills and technologies (1)	○	○	○	○	○
Uses verbal communication skills (2)	○	○	○	○	○
Uses listening skills (3)	○	○	○	○	○
Uses negotiation skills (4)	○	○	○	○	○
Uses conflict resolution skills (5)	○	○	○	○	○
Uses facilitation skills (group work) (6)	○	○	○	○	○
Uses interpersonal skills (individual and teams) (7)	○	○	○	○	○
Uses collaboration and partnering skills (8)	○	○	○	○	○
Attends to issues of diversity and culture (9)	○	○	○	○	○
Demonstrates professional credibility (10)	○	○	○	○	○

Q6 What is your current or last position role in a public health setting?
- ○ Appointed position (1)
- ○ Management (2)
- ○ Staff (3)
- ○ Independent contractor (4)

Q7 Do you have experience supervising evaluators?
- ○ Yes (1)
- ○ No (2)

Q8 What types of organizations do you or have you worked in related to public health? Check all that apply.
- ❑ Government (1)
- ❑ Healthcare (2)
- ❑ Nonprofit (3)
- ❑ Academic (4)
- ❑ Business (5)
- ❑ Other: Please specify (6) _____

Q9 How many years have you worked in a public health setting (total)?
- ○ 1 or less (1)
- ○ 2-5 (2)
- ○ 6-10 (3)
- ○ 11-15 (4)
- ○ 16 + (5)

Q10 What is your highest level of education?
- ○ Doctoral (1)
- ○ Master (2)
- ○ Bachelor (3)
- ○ Associate (4)
- ○ None (5)