Becoming a Health Education Profession: Key to Societal Influence 1995 SOPHE Presidential Address

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The theme of the 1995 SOPHE annual meeting was *power, politics, and prevention.* Prevention is a recurring theme with health education, and although power and politics are less frequently occurring themes, these topics are discussed with increasing frequency in the literature, at conferences, and particularly over the internet. Understanding group dynamics and power is a basic skill of community health organization and development, and the study of groups is basic to the professional preparation of health educators.[1] Power within the study of groups can be viewed as the ability to influence others and classic descriptions of the ability to influence others include expert power, referent power, legitimate power, and power from the ability to reward and punish.[2] Key to influencing people is having status with those who are to be influenced, and the lack of sufficient societal influence by health education has been the most recurring theme that I have encountered during my term as president of SOPHE.

VIEWING HEALTH EDUCATION AS A PROFESSION

The sociological construct for an occupation that has special status is the "profession." Most of the early study of professions by sociologists focused on what distinguished professions from other occupational groups.[3] Most of the early works through the 1960s emphasized specific characteristics of professions.[4,5] Examples of the characteristics include qualities that are now widely recognized as being associated with professions, such as a code of ethics, a national organization, and a form of credentialing usually involving licensing, journals, a special language, and so forth.

While health education has many of the characteristics of a profession, few would argue that health education has the same level of influence of some of the more recognized professions. However, it is not clear that it is in society's or even the practitioner's interest for health education to attain all of the characteristics of the more recognized professions. For example, the value of a separate language is debatable. The use of a unique language is frequently justified as necessary for precision, as can be illustrated with medical terminology, but others argue that the special language is simply a means of separating the practitioners from those who they serve and requiring the public's unquestioning trust of the practitioners. Health education has a primary purpose of communicating messages to the public, and heavy use of a unique language might undermine that basic purpose.

Use of a unique health education language may be appropriate for some of the more technical aspects of health education, but even here the value may be questioned. The use of terms such as *impact* and *outcome*,[6,7] in contradiction to how the terms are used by evaluators from other professions,[8,9,10] illustrates the questionable value of a unique health education language. What is attained by calling knowledge and skills *impacts* rather than *outcomes*? Why not use the term *impact* as the term is used by other evaluators, to indicate the effect of a program, the extent of which is determined by the strength of the

research/evaluation design? Within that context, knowledge, skills, attitudes, healthful behaviors, and health status are all potential outcomes, and the degree to which any program has an impact on them is determined by the strength of the research design. What do practitioners or the public gain from this unique use of language by health education?

Another characteristic of professions where health education should proceed with more caution involves codes of ethics. The adoption of different codes of ethics by health education professional organizations (SOPHE & AAHE) is an example of a potential misapplication of characteristics of a profession that is detrimental to the profession rather than enhancing the profession. Two is not better than one if the result is a message that reinforces an impression that health education is a process involving multiple occupations lacking a single profession identity. There may be good reasons of which I am not aware for multiple codes of ethics, but it is hard to understand how multiple codes of ethics reinforce a clear identity for the profession.

AN ECOLOGICAL VIEW OF PROFESSIONS

Studying the characteristics of individual professions has been done by many emerging professions, and health education has successfully and appropriately adopted many of the identified characteristics of professions. But the more recent system approach to the study of competing professions[3] provides a stronger foundation for understanding health education's influence in society, particularly as the profession of health education relates to other occupational groups. The emphasis on the systems approach is on relationships rather than specific characteristics of a single profession. As useful as the studies of the characteristics of professions are to emerging professions, the ecological approach to professions facilitates a more goal-oriented approach related to what must be done to carve out an identity and role related to other professions. For example, Carpenter[11] emphasized the traditional role of credentialing related to improved standards in her response to the Public Health Credentialing Study.[12] But Livingood, Woodhouse, and Godin[13] emphasized the relationships to other professions rather than the internal value within the profession by pointing out that the data from their research[12] indicated that public health leaders placed greater value on credentialing for clarifying the nature of public health and distinguishing public health from others such as medicine. The differences in the responses of Carpenter versus Livingood et al. emanated from how they viewed professions, as a single entity versus one within a system of occupations.

Viewing health education as a profession within the context of competing groups of expert labor[3] presents several major challenges: (1) clarifying health education as a distinct practice identifiable as a distinct profession, (2) convincing society of the value of the practice as an identifiable profession, and (3) identifying the practitioners.

Most of health education's recent emphasis on developing as a profession has been on credentialing, which is primarily, but not solely, of value in identifying practitioners.[14,15,16] The focus of this address is more on clarifying the nature of health education as a profession rather than on credentialing.

Definitions of Health Education

Clarifying health education as a profession requires broad acceptance of what health education is. The process of clarifying health education is mostly attempted through

definitions of health education, and most of the efforts to define health education have focused on health education as a process. However, adding the concept of health promotion has confused the concept of health education as a process because the definition of health promotion related to health education has tended to limit concepts of health education by excluding concepts of community behavior as a legitimate purpose of health education. For example, Green et al.[17] defined health education as "any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health" (p. 7). The terms *learning experiences* and *voluntary behavior* used within this definition tend to give health education a focus on individuals. Green and Kreuter[7] also defined *health promotion* as "the combination of educational and environmental supports for actions and conditions of living conducive to health." While the evolution of this term was at least partially political, to facilitate government support for health-related behavioral interventions within the context of perceived political hostility to health education, its widespread use has had major social implications for how health education is defined. This concept implies that the physical and social environmental factors that influence behavior are separate from education. Green and his colleagues also developed the PROCEED model approximately a decade after PRECEDE to deal with some of the policy, regulatory, and organizational constructs found in the environment that they thought the PRECEDE model did not effectively address, also implying that these determinants found in the social environment are not influenced by education. PRECEDE was primarily designed as a educational planning model, whereas PRECEDE-PROCEED was designed for what the authors considered the broader concept of health promotion.

Others have defined health education to include group and community behaviors that lead to many environmental determinants. The following definition of health education has been one of the most enduring and widely recognized: "A Process with intellectual, psychological and social dimensions relating to activities that increase the abilities of people to make informed decisions affecting their personal, family and community well being" (p. 6). It was published in 1973 as the definition of health education recognized by the Joint Committee on Health Education Terminology.[18] It was later published as the definition of health education in the School Health report published by the Education Commission of the States.[19] Jorgensen cited this definition in her SOPHE presidential address on health education and health care reform just 2 years ago.[20]

Other definitions of health education have also included a broader focus than individual behaviors or decision making. For example, the following definition published with the Initial Role Delineation study clearly looked at groups (people acting collectively) as well as individuals as appropriate targets of health education: "The process of assisting individuals, acting separately and collectively, to make informed decisions about matters affecting their personal health and that of others" (p. 55).[21]

Much of the difference in definitions centers on the term *voluntary*, not only found in Green's definition of health education but found in recent codes of ethics for health education. This emphasis on individual voluntary behavior can conflict with the ability of communities to make decisions. A total emphasis on voluntary individual decisions can preclude a group decision. On the other hand, definitions of health education that recognize group and community behaviors and decision making imply that health education can lead to community decisions to discourage undesirable behaviors or encourage desirable behaviors. Is a seat belt law coercive because it imposes a $10 fine for noncompliance, or is it more of an educational tool, particularly if passed after community education and when coordinated with educational campaigns characterized

by the billboard, "It's not just a good idea; it's the law"? Can health education be used to influence community awareness, decision making, and implementation of such laws, or do such activities violate basic definitions and even codes of ethics of health education?

If community decisions and/or behavior are included in the definition of health education, it is in the interest of the profession to reconcile these more inclusive definitions of health education with such important models of health education planning as PRECEDE. The PRECEDE authors' definition of health education lacks reference to community and, when taken within the context of the definition of health promotion, actually limits health education. Minor modification of the PRECEDE model facilitates a concept of health education that more clearly recognizes community behavior as an outcome. We have been using such a modification of PRECEDE in the preparation of undergraduate and graduate health education students at East Stroudsburg University for over a decade.

In this modification of PRECEDE, individual behaviors are distinguished from community behaviors. Most of the enablers and the reinforcers (key PRECEDE concepts) are included under community behaviors and are analyzed during the behavioral analysis rather than the educational analysis. Community behaviors also would include behaviors leading to policy, regulatory, and organizational change in addition to enablers and reinforcers. The educational analysis following the analysis of individual and community behaviors in the modified PRECEDE concentrates on traditional educational outcomes of knowledge, attitudes, and skills. This modification of PRECEDE is different in that skills are grouped with the more traditional educational outcomes of knowledge and attitudes instead of as enablers as they are in the unmodified PRECEDE model. This minor modification or reorganization of PRECEDE facilitates a distinction between individual and community behaviors but also facilitates the inclusion of both in health education planning and evaluation.

Evaluation of health education process and outcomes is also simplified with this modification of PRECEDE that recognizes community behaviors as a legitimate outcome of health education. By recognizing community behaviors as a legitimate outcome of health education, the needs for a definition of health promotion and the addition of the PROCEED model to supplement definitions of health education emphasizing the individual are reduced.

Although some influences on health education (such as traditional health care reimbursement, philosophies such as humanism, and applied psychology such as the transtheoretical model) continue to restrict health education focus on the individual, other trends strengthen the health education emphasis on community and enhance recognition that community is more than a group of individuals acting independently. The health care system is frequently criticized for its lack of population-based emphasis. For example, the first Pew Health Professions Commission report criticized the training and preparation of most health-related professions for their lack of population-based emphasis, but public health was notably recognized for this emphasis. Health education overlaps with public health in this population-based focus.

Schools are also increasingly recognizing broader community-oriented approaches beyond the classroom. For example, a recent evaluation of school-based health centers in Pennsylvania revealed a large number of elementary school children with low hemoglobin, whose hemoglobin was subsequently elevated through a parent and community education program conducted by the school nurse.[22] The cause of the low hemoglobin was determined to be poor nutrition, but education of the affected younger elementary children alone would not have been likely to produce an effect, since the children have

little control over their food choices. The increased hemoglobin followed education of people (primarily parents) in the children's environment.

This emphasis on community in health education research also can be verified in the literature. The Guy Steuart anthology[23] and two community empowerment special issues of *Health Education Quarterly*[24,25] are particularly notable examples of the health education emphasis on community, but examples abound throughout the health education journals, including the emphasis on community in the research agenda published recently in *Health Education Quarterly*.[26] The traditional and increasing inclusion of a broader range of community sensitive disciplines such as anthropology and sociology to both research methods and theories will give health education even stronger foundations for the inclusion of community as a target of health education.

DEFINING HEALTH EDUCATION AS A DISCIPLINE

One approach to reconciling differences in defining health education is to emphasize the definition of health education as a discipline in clarifying the role of health education as a profession. "The ability of a profession to sustain its jurisdiction lies partly in the power and prestige of its academic knowledge" (pp. 53-54).[3] Health education as a profession can be conceptualized as an occupation involving the processes of both health education and health promotion, but simply staking such a claim does not provide a moral or intellectual foundation for societal influence. Regardless of whether the discipline of health education includes the processes of health education and health promotion or simply the process of health education that is defined more broadly to include community behavior, clarifying the discipline of health education is needed for clarification of health education as a profession, particularly as the profession of health education relates to other professions.

Within the context of competition with other professions, defining the profession of health education vis-à-vis defining the discipline of health education involves several critical elements. Within this context, health education must (1) be of value to society, (2) be unique enough to be the foundation for a distinct profession, and (3) be of sufficient complexity to be more than an occupational grouping of technicians. This final point presents problems and even contradicts health education's efforts to simplify and disseminate its practices.

This process of defining our distinct discipline creates opportunities related to societal influence and social jurisdiction. In defining health education as a discipline, particular attention should be paid to the shortcomings and mistakes of other professions, such as the monopolistic practices and inbreeding that characterizes some professions. Not replicating the shortcomings of other professions and not making the mistakes of other professions provide opportunity for health education to be both unique and of value to society. This opportunity is enhanced if the weaknesses of other professions are traditional strengths of health education.

The Pew Health Professions Commission report on professional preparation outlined a number of weaknesses in the professional preparation of medical practitioners.[27] The need for preparation of practitioners for the medical profession to be more population- versus client-centered, more interdisciplinary, more prevention-oriented, and more community-centered contrasts with the Pew report's recognition that these are strengths of public health professional preparation.

The Pew report[27] specifically recommended that some of the characteristics of public health professional preparation should be emulated by other health-related professions. Many of these recommended qualities overlap with health education. What public health is criticized for, the lack of clarity and consistency in professional preparation, is even more true of health education.

The broad institution of public health, which overlaps with many societal structures, is particularly important to health education. The *Future of Public Health* report[28] defined the substance of public health as "organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology" (p. 41). This definition of public health provides particular overlap with health education. Not only is the outcome similar to health education but many public health entities recognize health educators as the "community organization people," a basic component of the definition of public health. Health education has a rich tradition of research and practice with community development, community organization, and community empowerment, particularly when compared to other public health–related disciplines. Health education is unique as a discipline within public health in that it has specific accreditation status that is afforded no other discipline and the standards for that accreditation include community organization.[29]

So how do we define health education as a discipline that builds on health education traditions and position health education as a viable profession within the context of competing professions? Clearly health education should avoid the inbreeding, lack of communication, and self-limiting insight for which other professions are criticized but still provide a unique valuable service to society. The following is a composite definition, reflecting both previous definitions and traditions of health education as a discipline and attempting to provide clarity while avoiding some of the common problems associated with defining a discipline. As a discipline, health education is an interdisciplinary applied science to prevent disease and enhance the health of individuals and groups (including families and communities) through learning and developmental activities that affect future behavior and decision making with emphasis on processes involving innovation and problem solving rather than prescriptive, technician-oriented processes.

Each dimension of the definition of health education merits discussion.

Interdisciplinary applied science—The interdisciplinary and practical nature of health education as a discipline is found in other literature,[30,31] and it is one of health education's strongest assets as a profession.

To prevent disease and enhance the health—Health education traditions and purposes are more in common with public health as a profession rather than allied health or medical professions. This is true related to a number of qualities such as a population rather than client focus in addition to the prevention and health versus treatment and illness emphasis.

Of individuals and groups—Rationales and traditions of including more than individuals such as communities and families were discussed previously.

Through learning and developmental activities that affect future behavior and decision making—The term *learning* is more associated with experiences affecting the future behavior of individuals, whereas the term *development* is more applicable to experiences effecting future behaviors of communities. Similarly, we use the term *skills* more for individuals, but the term *capacity* is applied to community for a similar concept.

With emphasis on processes involving innovation and problem solving rather than prescriptive, technician-oriented processes—Literature on professions clearly identifies the need for an abstract body of knowledge rather than a more simply and rigidly defined

body of knowledge associated with technical occupations. This concept of an abstract body of knowledge is also more associated with public health in contrast to allied health professions that tend to include occupational groups of technicians.

CHALLENGES TO THE PROFESSION

To build on this definition of health education as a discipline and enhance health education's status as a profession, I recommend professional organizations and individual practitioners consider the following:

1. Continue to develop unique health education approaches (models, theories, methods, etc.) related to the discipline of health education. PRECEDE is an example of a health education model that has attained worldwide and interdisciplinary recognition, but it is also a model that builds on the theories of other disciplines such as epidemiology and psychology.
2. Institutionalize the interdisciplinary nature of health education, particularly related to but not restricted to behavioral, health, and communication sciences. Health education should avoid the tendency of other professions to become inbred as they mature. The synthesis of many disciplines within health education has been one of its greatest assets and health education should make sure that asset is preserved. Some means of preserving the interdisciplinary nature are:
   a. Require another degree from a different discipline in the credentialing process, especially for upper level credentials;
   b. require demonstrated competence in other disciplines (in the way many PhD programs require a research tool such as demonstrated skills in language or statistics);
   c. require courses from other disciplines through accreditation and certification processes; and
   d. require minimum achievement through skills tests related to other disciplines.
3. Build on health education traditions and accomplishments (organizations, practices, credentials) that clearly communicate a health education discipline with an emphasis on community development/organization.
4. Recognize and build on health education's diversity.
   a. For health education organizations, accept the need for multiple organizations but facilitate or ensure collaboration between the organizations, respecting one another's contributions, not trying to duplicate or displace other organizations, competing with one another where appropriate, such as where organizations are not adequately addressing the needs of health educators or society, and avoiding competition resulting in unnecessary mixed messages being sent to society such as multiple codes of ethics. The Coalition of National Health Education Organizations is particularly critical to this collaboration.
   b. Promote, encourage, and accept differences in theories, methods, and models. Even questioning the value of theory-based programs[32,33] should be viewed as enriching rather than destructive because it expands the epistemological foundations of what we do as health educators to include more postmodernist paradigms.
   c. Expand the diversity of people, with larger representation of minorities.

5. Build on health education's cross-institutional status in society related to education (such as separate teacher certification) and public health (such as separate accreditation for graduate community health education programs by the established public health accrediting body, the Council on Education for Public Health).
6. Build on health education's population-based versus client-based orientation to the public we serve. Many health-related professions recognize this need, but the fee-for-service relationship of most health care professions impedes progress for most professions. For example, the profession of social work had a greater emphasis on community organization in its early development, but as it attained greater recognition and status including fee-for-service payment for counseling, the profession has directed more and more of its energies to serving individuals. This is a trap that health education should avoid.

ROLE OF SOPHE

SOPHE and its members play a vital role in the continued development of the health education profession. In addition to the preceding recommendations that are more of a challenge to the profession of health education, its institutions, its organizations, and its practitioners, SOPHE and its members should do the following:

Recognize that health education as a service to society and health education as a profession are more important than any single organization including SOPHE.

Build on SOPHE's reputation and traditions. One of the things that has impressed me most, during my tenure as president, is SOPHE's unique, special status within the public health community and the health education community. The status of SOPHE has given the profession of health education status, and health education cannot afford to lose that status.

Build on SOPHE chapters, especially during times when government decision making is shifting to state and local levels. SOPHE chapters are the only national system of local health education organizations and the chapters are a critical asset to SOPHE and the profession of health education.

Expand membership in SOPHE. The larger SOPHE is, the more influence and resources that health education can have and the more the profession of health education can capitalize on SOPHE's status. A number of initiatives are already underway, and SOPHE is in very good position to increase its membership because it offers a number of services at a relatively low cost. For example, membership and continuing education credits are much lower for SOPHE than for other organizations. A new membership category has been started and it is already attracting new members. Over a 50% increase in membership occured since these changes were begun, the first increase of any substance in many years.

Enable SOPHE to interact more effectively in national health and education policy development. Surveys have indicated that this is the greatest perceived need of our membership, and it is a recurring issue among health educators. Major steps are already under way to increase SOPHE's effectiveness in improving health education. A full-time paid executive has already been hired, and relocation of the national office to Washington, DC, has been completed.

Thank you for the opportunity to serve you during this exciting period of evolution for SOPHE and the profession of health education.

References

1. National Task Force on the Preparation and Practice of Health Educators, Inc.: *A Framework for the Development of Competency-Based Curricula for Entry Level Health Educators.* New York, NY, 1990.
2. French JRP, Raven B: The basis of social power, in Cartwright D, Zandler A (eds.): *Group Dynamics.* Evanston, IL, Row and Peterson, 1960, pp. 607-623.
3. Abbott A: *The System of Professions.* Chicago, IL, University of Chicago Press, 1988.
4. Etzioni A: *The Semi-Professions and Their Organization.* New York, NY, Free Press, 1969.
5. Moore WE: *The Professions: Roles and Rules.* New York, NY, Russell Sage Foundation, 1970.
6. Sarvela PD, McDermott RJ: *Health Education Evaluation and Measurement.* Madison, WI, WCB Brown & Benchmark, 1993.
7. Green L, Kreuter M: *Health Promotion Planning: An Educational and Environmental Approach.* Mountain View, CA, Mayfield, 1991.
8. Scheirer MA: Designing and using process evaluation, in Wholey JS, Hatry HP, Newcomer KE (eds.): *Handbook of Practical Program Evaluation.* San Francisco, CA, Jossey-Bass, 1994.
9. Rossi PH, Freeman HE: *Evaluation: A Systematic Approach* (4th ed.). Newbury Park, CA, Sage, 1989.
10. Schalock RL, Thornton CVD: *Program Evaluation: A Field Guide for Administrators.* New York, NY, Plenum, 1988.
11. Carpenter ES: Is public health credentialing necessary? *Am J Public Health* 85(12):1713, 1995.
12. Livingood WC, Woodhouse LD, Godin SW: The feasibility and desirability of public health credentialing: A survey of public health leaders. *Am J Public Health* 85(6):765-770, 1995.
13. Livingood WC, Woodhouse LD, Godin SW: Livingood and colleagues respond. *Am J Public Health* 85(12):1713, 1995.
14. Livingood WC, Woodhouse WD, Godin SW, et al: Credentialing and competition for social jurisdiction. *J Health Educ* 24(5):282-284, 1993.
15. Girvan JT, Hamburg MV, Miner KR: Credentialing the health education profession. *J Health Educ* 24(5):260, 1993.
16. Alperin M, Miner KR: Professional relevance: Meeting the contemporary public health agenda. *J Health Educ* 24(5):299-304, 1993.
17. Green L, Kreuter MW, Deeds SG, et al: *Health Education Planning: A Diagnostic Approach.* Palo Alto, CA, Mayfield, 1980.
18. Society for Public Health Education: New definitions: Report of the 1972-1973 Joint Committee on Health Education Terminology. *Health Educ Mono* 6:85, 1973.
19. Education Commission of the States: *Recommendations for School Health Education: A Handbook for State Policymakers.* Denver, CO, 1981.
20. Jorgensen CM: Health education: What can it look like after health care reform? 1993 SOPHE Presidential Address. *Health Educ Q* 21(1):11-26, 1994.
21. National Center for Health Education: *Initial Role Delineation for Health Education: Final Report.* The Department of Health and Human Services, 1980.
22. Livingood WC, Woodhouse LD, Godin SW: *Pennsylvania Elementary School Based Health Centers: Summative Evaluation (Preliminary Report).* Report submitted to the Pennsylvania Department of Health, 1995.
23. Steckler AB, Israel BA, Dawson L, Eng E (eds.): Community Health Development: An Anthology of the Works of Guy W. Steuart. *Health Educ Q* (supple. 1), 1993.
24. Wallerstein N, Bernstein E (eds.): Community Empowerment, Participatory Education, and Health-Part I (Special issue). *Health Educ Q* 21(2), 1994.
25. Wallerstein N, Bernstein E (eds.): Community Empowerment, Participatory Education, and Health-Part II (Special issue). *Health Educ Q*, 21(3), 1994.
26. Clark NM, McLeroy KR (eds.): Creating Capacity: A Research Agenda for Public Education (Special issue). *Health Educ Q* 22(3), 1995.
27. Pew Health Professions Commission: *Health professions education for the future: Schools in service to the nation.* San Francisco, CA, 1993.

28. Institute of Medicine: *The Future of Public Health.* Washington, DC, National Academy Press, 1988.
29. Council on Education for Public Health: *Accreditation Criteria: Community Health Education Graduate Programs.* Washington, DC, Council on Education for Public Health, 1994.
30. Pollock M: *Planning and Implementing Health Education in Schools.* Palo Alto, CA, Mayfield, 1987.
31. Butler JT: *Principles of Heath Education and Health Promotion.* Englewood, CO, Morton, 1994.
32 McLeroy D, Steckler AB, Simmons-Morton B, Goodman RM, Gottlieb, Burdine JN: Social science theories in health education: Time for a new model? *Health Educ Res* 8(3):305-312, 1992.
33. Green LW, Glanz K, Hockbaum CM, Kok G, Kreuter MW, et al: Can we build on, or must we replace, the theories and models in health education? *Health Educ Res* 9(3):397-404, 1994.

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