



Evaluation Report of the Great Plains Public Health Training Center For the Reporting Period of July 1, 2011 to June 30, 2012

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the Reporting Period of July 1, 2011 to June 30, 2012

NOTE: All results show valid percentage unless otherwise labeled. All percentages are rounded to the nearest whole figure unless otherwise presented. Total percentages may thus occasionally sum to more than 100 percent.

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SUMMARY

The Great Plains Public Health Training Center (Training Center) is one of thirty eight public health training centers currently funded in the United States. The Training Center program was established in 2000 by the U.S. Health Resources and Services Administration. The Great Plains Public Health Training Center was established in 2011 through grant funding provided to the University of Nebraska Medical Center College of Public Health. Highlights of activities and findings from the Training Center's first year (FY 2011-2012) include the following:

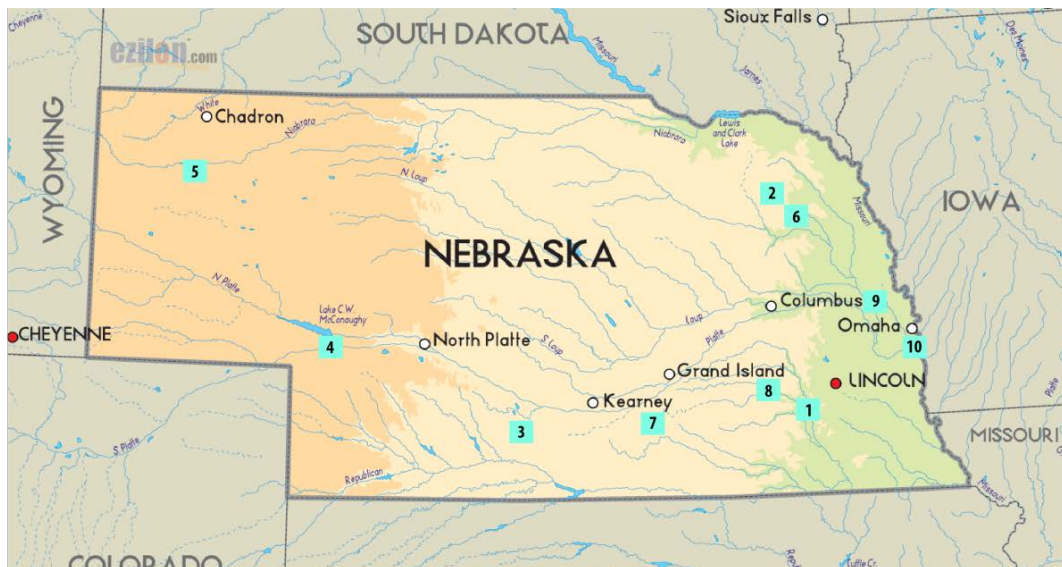
- The Training Center sponsored or co-sponsored eleven continuing education events aimed at the current and future public health workforce. A total of 359 trainees participated in the Training Center's continuing education events. 220 of those trainees were unique individuals.
- The Training Center established a field placement program which placed ten field placement interns at local public health departments or organizations across the state of Nebraska, including in Crete, Fremont, Hastings, Hemingford, Holdrege, Ogallala, Omaha, Wayne, Wisner, and York.
- Continuing education trainees were predominantly female (224/74%) and white (232/80%). Continuing education trainees were 9% Latino/Hispanic and 18% non-white.
- 79% of continuing education trainees believed their knowledge of public health topics increased as a result of participating in the Training Center's continuing education events.
- 82% of continuing education trainees would recommend the Training Center's continuing education events to colleagues.
- The majority of continuing education participants were students or academics (45%), followed by state government (16%) and local government (13%) employees.
- Continuing education trainees believed that among public health core competencies, they were most skilled in the area of cultural competency (3.52/5), and least skilled in the areas of financial planning (3.09/5) and policy development/program planning (3.09/5). Continuing education trainees also indicated that they had under-average skill levels in HIV/AIDS related programming skills (2.91/5) and knowledge of public health skills related to Tribal public health (2.42/5).
- Experiential trainees believed that among public health core competencies, they were most skilled in the area of analytic/assessment skills (3.58/5), and least skilled in the areas of financial planning (2.94/5). Continuing education trainees also indicated that they had under-average skill levels in public health skills related to Tribal public health (2.54/5).
- The most preferred setting and format among Training Center participants for continuing education was single-day, in-person training sessions.
- The most preferred characteristic of continuing education training opportunities was face-to-face time with instructors and other trainees.

OVERVIEW OF ACTIVITIES

The Great Plains Public Health Training Center (Training Center) conducted numerous activities in its first year. The Center established a coordinating structure and leadership committee with responsibility for implementing and administering training activities. The Training Center was well positioned to begin offering educational activities at an early stage, and in the reporting year offered a total of eleven continuing education activities for trainees. The continuing education activities were primarily presentation and discussion forums featuring public health experts on a variety of topics. Trainees could participate in these forums in person, or via webcast, satellite television or conference call.

The Training Center also designed and initiated a 200 hour field placement program for its first cohort of students. Ten field placement experiences were initiated in the reporting period throughout the state (see Figure 1). The field placements were designed to link trainees with local or tribal health departments in Nebraska that were in need of assistance with public health-related projects, and could in turn offer practical and meaningful guidance through both a designated site supervisor and a Training Center mentor. Field placement training experience topics ranged from tobacco/alcohol/drug prevention to farm safety to community needs assessment projects.

Figure 1. Field Placement Sites



- 1 Public Health Solutions, Crete, NE (car seat safety, farm safety, bicycle safety).
- 2 Northeast Nebraska Public Health Department, Wayne, NE (MAPP process, West Nile project).
- 3 Two Rivers Public Health Department, Holdrege, NE (MAPP process, priority resolution).
- 4 Sandhills Clinic and Public Health Department, Ogallala, NE (immunizations, grant writing).
- 5 Panhandle District Health Department, Hemingford, NE (maternal and child health care, Hispanic and Native American outreach).
- 6 Elkhorn Logan Valley Public Health Department, Wisner, NE (tobacco, alcohol, and drug prevention).
- 7 South Heartland Public Health District, Hastings, NE (MAPP process, physical activity in adults).
- 8 Four Corners Public Health Department, York, NE (Spanish-language materials development, Hispanic outreach).
- 9 Three Rivers Public Health Department, Fremont, NE (community needs assessment).
- 10 Nebraska Urban Indian Health Coalition, Omaha, NE (urban Indian health, grant writing).

Structured program activities for field placement students included monthly conference calls and reflection papers, participation in a blog, an in-person meeting among all field placement students, and a capstone presentation at the Public Health Association of Nebraska meeting at the completion of the field placement program.

The Training Center also established a coordinating structure for their collaborative projects program. The collaborative projects program supports applied research projects that are collaborations between public health faculty, students and practitioners in various public health topics across the state. At the end of the reporting period, two collaborative projects were established. Four more projects were established in the early part of the second reporting period. Topics for collaborative project topics include:

- *Characterization of Indoor Air Quality in Residences and Schools on the Winnebago Reservation* – A partnership between the Winnebago Health and Human Services (<http://www.winnebagoohhs.com/>) and UNMC College of Public Health to characterize and measure indoor air quality in homes and schools on the Winnebago reservation.
- *Nebraska Adult Sexual Literacy Project (NASLiP)* – A partnership between the Midlands Sexual Health Research Collaborative (<http://www.unmc.edu/publichealth/mshrc.htm>) and the Nebraska Sexual Health Coalition to research and address sexual literacy issues across the state.
- *Douglas County Department of Corrections HIV Opt-In Testing Pilot Project* – A partnership between the Douglas County Department of Corrections (<http://www.dccorr.com/corrections/>), Douglas County Health Department (<http://www.douglascountyhealth.com/>), UNMC Colleges of Public Health and Medicine to reduce incidence of HIV and other sexually transmitted diseases among high risk individuals.
- *Health Policy Short Course for Local Health Departments in Nebraska* - A partnership between the Nebraska Department of Health and Human Services (<http://dhhs.ne.gov/Pages/default.aspx>) and the UNMC College of Public Health to develop and offer a short course on health policy to public health professionals across the state.
- *Public Health Early Admissions Student Track (PHEAST) Project* – A partnership between Chadron State College (<http://www.csc.edu/>), Peru State College (<http://www.peru.edu/>), Wayne State College (<http://www.wsc.edu/>), and the University of Nebraska at Kearney (<http://www.unk.edu/>) to recruit and mentor students for early admission into the UNMC College of Public Health Master’s of Public Health program.
- *Health Literacy Nebraska Project* – A project between Health Literacy Nebraska (<http://www.healthliteracyne.org/>) and the Northeast Nebraska Public Health Department (<http://www.nnphd.org/>) to build awareness and increase and coordinate health literacy initiatives across the state.

A statewide needs assessment was also conducted by the Training Center. The purpose of the needs assessment was to gauge the skill levels of the state’s public health workforce to help determine Training Center programming. As part of the assessment, an online survey was developed and provided to 341 tribal, state, local, and other public health organizations in Nebraska. 131 survey responses were collected by the assessment’s researchers. Additionally, 15 interviews were conducted of public health stakeholders and organization leaders. The survey and interview data were analyzed and recommendations made for training center activities.

Finally, the Training Center began developing the infrastructure for an online Learning Management System (LMS). Content for training was still being developed at the close of the reporting period, and the LMS is scheduled to become fully operational in year 2 of the Training Center.

CONTINUING TRAINING ACTIVITIES

The Great Plains Public Health Training Center (GPPHTC) convened or co-sponsored a total of eleven training events from the July 1, 2011 to June 30, 2012 reporting period. Those events included:

November 16, 2011: Leadership Training and Conflict Mining Workshop, Part I.

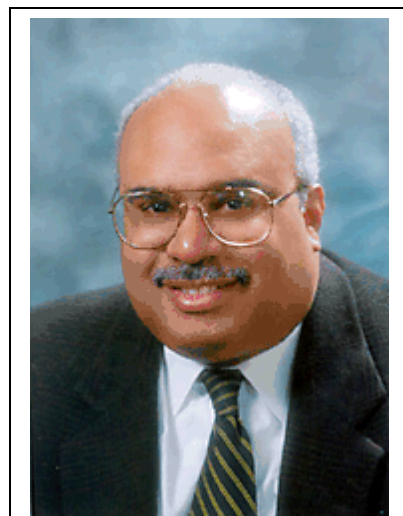
Location: One World Community Health Center, Omaha, NE. (<http://oneworldomaha.org/>)

The purpose of this workshop was to concentrate on basic public health leadership skills for community health workers, with a particular focus on skills pertinent to working with lower income and vulnerable populations.

January 20, 2012: University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Georges Benjamin.

Location: University of Nebraska Medical Center, Omaha, NE.

Dr. Georges Benjamin, Executive Director of the American Public Health Association (APHA, <http://apha.org/>), discussed the historical and current activities of the APHA and future challenges for the organization and the public health workforce in general. The discussion was carried by satellite broadcast and teleconference throughout the state of Nebraska.



Dr. Georges Benjamin, APHA.

January 26, 2012: Leadership Training and Conflict Mining Workshop, Part II.

Location: One World Community Health Center, Omaha, NE.

This activity was a continuation of the earlier workshop on basic public health leadership skills for community health workers.



Dr. Michael Fraser, AMCHP.

March 8, 2012: The Challenges We Face, the Leaders We Need - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Fraser.

Location: University of Nebraska Medical Center, Omaha, NE.

Dr. Michael Fraser, Chief Executive Officer of the Association of Maternal and Child Health Programs (AMCHP, <http://www.amchp.org/>), discussed issues of leadership, resiliency, advocacy, innovation, and commitment to equity within the context of maternal and child health

and public health in general. The discussion was carried by satellite broadcast and teleconference throughout the state of Nebraska.

April 2, 2012: National Public Health Week: Community Kick-off Events

Location: South Omaha Library, Omaha, NE.

In observance of National Public Health Week, the University of Nebraska Medical Center's Office of Public Health Practice sponsored a panel discussion of child, adolescent, women, and family health issues in the Omaha community. The panel included health experts and advocates from a variety of area organizations, including:

Mary Baluff, Douglas County (Omaha) Health Department (<http://www.douglascountyhealth.com/>)

Willie Barney, The Empowerment Network (<http://www.empoweromaha.com/>)

Kerri Peterson, Live Well Omaha (<http://livewellomaha.org/>)

Carolyn Rooker, Nebraska Voices for Children (<http://voicesforchildren.com/>)

Jennifer Skala, Nebraska Children and Families Foundation (<http://www.nebraskachildren.org/>)

Fawn Taylor, Building Bright Futures (<http://buildingbrightfutures.net/>)

The panel was moderated by Dr. Renaisa Anthony, Deputy Director of the University of Nebraska Medical Center's Center for Reducing Health Disparities (<http://www.unmc.edu/publichealth/crhd.htm>), and featured remarks by Dr. Ayman El-Mohandes, Dean of the University of Nebraska Medical Center College of Public Health.

April 6, 2012: Behavioral Health: Why It Matters to Public Health and What to Do About It - University of Nebraska Medical Center Leadership Speaker Series, featuring Laura Howard.

Location: University of Nebraska Medical Center, Omaha, NE.

Laura Howard, Regional Administrator for Region VII of the Substance Abuse and Mental Health Services Administration, discussed mental health and substance abuse issues within the context of public health in general. The discussion concluded the American Public Health Association Region VII annual meeting hosted by the College of Public Health. The discussion was carried by satellite broadcast and teleconference throughout the state of Nebraska.

May 24, 2012: Co-Creating the Future and Sustaining the Past: A Nebraska Public Health Nursing Summit

Location: Lincoln, NE.

This conference was convened by the Public Health Association of Nebraska's (<http://www.publichealthne.org/>) Public Health Nursing section with the support of Training Center funding. The purpose of the conference was to outline major priorities, issues, and potential solutions for public health nursing at national and local levels, articulate the functions of public health nursing in population and community health priorities, and describe the National Prevention Strategy and how it can be used in local practice and nursing education. The keynote speaker was Susan Swider, a professor at Chicago's Rush University College of Nursing and expert in program development and evaluation of community health workers and engaging urban communities in health promotion.

June 13-15, 2012: Health Center Association of Nebraska Symposium 2012: Leading Change

Location: Nebraska City, NE.

This conference was convened by the Health Center Association of Nebraska (<http://hcanebraska.org/>) with the support of Training Center funding. The symposium featured a keynote speech from Pamela McManus, CEO of Peak Vista Community Health Centers in Colorado (<http://peakvista.org/>) about the importance of promoting cultures of hospitality, and skills-based training workshops on management skills for leaders, facilitated by Dr. Neil Baker of Neil Baker Coaching and Consulting, LLC

(<http://www.neilbakerconsulting.com/>) and establishing and leading effective care teams, by Sheila Richmeier of Remedy Healthcare Consulting, LLC (<http://www.remedyhealthcareconsulting.com/>).

June 19, 2012: 7th Annual Tribal Leader/Scholar Program at the National Congress of American Indians' Mid-Year Conference.

Location: Cornhusker Hotel, Lincoln, NE.

Trainees were invited to attend a session on community and environmental health at the 7th Annual Tribal Leader/Scholar Program at the National Congress of American Indians' (NCAI) Mid-Year Conference. The session included presentations from a variety of tribal-based community and environmental health initiatives. The session was convened as part of the NCAI conference.



Dr. Michael Reece, Indiana University School of Public Health.

Panel session presenters included presentations on tribal health assessments, water and wastewater infrastructure development projects, wildfires threat assessment and prevention, and climate variability adaptation strategies by tribal communities, among other topics.

June 20, 2012: Nebraska Sexual Health Research in the 21st Century: Innovations and Future Directions - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Reece.

Location: University of Nebraska Medical Center, Omaha, NE.

Dr. Michael Reece, Associate Dean for Research and Graduate Studies at the Indiana University School of Public Health

(<http://pbhealth.iupui.edu/>), discussed the current state and future

directions of sexual health research. The discussion was carried by satellite broadcast and teleconference throughout the state of Nebraska.

June 21, 2012: The Waponahki Tribal Health Assessment: A multi-tribal collaboration between members of the Waponahki Confederacy and the University of Nebraska Medical Center, College of Public Health, featuring Patricia Knox-Nicola.

Location: University of Nebraska Medical Center, Omaha, NE.

Patricia Knox-Nicola, Penobscot Nation Health Center, provided an overview of the Waponahki tribal health assessment, a partnership between the multiple tribal governments and the University of Nebraska Medical Center (<http://www.penobscotnation.org/IHS/>).

The discussion was carried by satellite broadcast and teleconference throughout the state of Nebraska.



Patricia Knox-Nicola, Penobscot Nation Health Center

EVALUATION METHODOLOGY

The evaluation of the Training Center is designed to measure impact on trainee competencies and trainee satisfaction, and gather requisite data from trainees on demographic and professional background. The evaluation is designed to track trainees over time to determine changes in core competency levels before and after participation in Training Center activities. Additionally, interviews with trainees are also being conducted to augment survey data. The evaluation data reported in this report features data collected for the first reporting period of the Training Center.

The evaluation team designed several survey instruments to collect evaluation data. A **pre-event survey** was constructed which contained mainly demographic and professional items as required by the US Health Resources and Services Administration (HRSA). The pre-event survey also contained items asking respondents to assess their skill levels of the core public health competencies. Two versions of **post-event surveys** were also developed, a **post-continuing education training activity survey** and **experiential survey**. These surveys were designed to largely collect information on respondents' perceptions of their training experience.

The evaluation team obtained approval from the University of Nebraska Medical Center Institutional Review Board to administer the evaluation. The data collection process included administering a pre-event survey prior to any training activities commencing, and then administration of a post-event survey immediately following those activities. Both surveys were linked by a unique pre-determined survey number that was also linked to Training Center participants through the use of registration or sign in sheets.

There are two limitations that should be noted about the evaluation. First, data was collected from most but not all of the training activities. In the case of two training events (the May 24th Public Health Nurses summit and June 13-15 Health Center Association of Nebraska symposium), partners preferred not to use the evaluation surveys developed by the evaluation team. Data was collected for all of the remaining training center activities, but surveys were not linked to individuals at several of the early continuing education activities, as IRB approval had not yet been provided. At those early events, only required HRSA evaluation data was requested of Training Center participants, and rosters of participants were also collected, but participant identities were not linked to the collected data. Full implementation of the evaluation data collection did not occur until April of 2012. Second, HRSA changed its required data collection measures shortly before the end of the reporting period. Thus, almost all the demographic and professional level data that was asked of Training Center participants do not correspond to the currently used HRSA performance measures. However, the experiential trainees were asked to retake an updated version of an evaluation survey to collect those new performance measures, and that information is included in this report.

Because identifying information was collected for the Training Center participants, it is possible to identify how many overall participants were "unique" versus how many are "duplicates" (i.e. the same person attending an activity two or more times). That information is reported here (see "Who Is Participating In The Great Plains Public Health Training Center?").

Additional information that also composes the overall evaluation process included the collection of information on specific Training Center activities, and Field Placement sites. The evaluation team developed questionnaires that were administered with either Training Center staff or Field Placement hosts to collect that information, which will also be provided to HRSA as part of the evaluation process. Also, telephone interviews were conducted with field placement students to collect data on how they perceived the field placement experience.

Finally, we were able to identify specific activity dates for unique Training Center participants that represent when they first provided us with survey information that can be linked directly to them. These data points will be used in analysis that will be conducted after a one year period from their original entry into our sample.

RESULTS

Who Is Participating In The Great Plains Public Health Training Center?

Definitions

Two principal types of individuals participated in GPPHTC activities during the reporting period, those individuals who participated in **continuing education** activities (single or multi-day lectures or workshops), and those individuals who participated in **experiential** activities (longer term field placement or collaborative project activities).

The vast majority of individuals we surveyed joined the continuing education activities. It is important to note that many of these continuing education trainees participated in multiple events. Therefore, we can report participant data for continuing education trainees in two ways. First, the **total number of continuing education activity participants** represents the total number of all people who participated in all continuing education activities, and counts individuals *multiple times if they participated in multiple events*. Secondly, we can identify **unique continuing education activity participants**, i.e., all individuals who participated in continuing education activities *one time* during the reporting period.

A much smaller number of individuals participated in experiential activities. These individuals were primarily students who participated in field internships with local or tribal health departments or became involved in collaborative public health projects during the summer of 2012. We will refer to them as **unique experiential activity participants**.

For purposes of developing a profile of who participated in the GPPHTC during the reporting period, we combine **unique continuing education activity participants** and **unique experiential activity participants**. This combined figure is the **total unique participants** in the reporting period. During the July 1, 2011 to June 30, 2012 reporting period, there were a total of 233 total unique participants, including 220 **unique continuing education activity participants** and 13 **unique experiential activity participants** (see Table 1).

Table 1. Total Unique Participants

Unique continuing education activity participants	Unique experiential activity participants	Total unique participants
220	13	233

Unique Participant Demographics

The majority of total unique participants were female (157/72%) (see Table 2). Approximately 9% of training center participants were of Hispanic/Latino origin (see Table 3). Seventeen percent (17%) of total unique participants were racial minorities, the majority of who were of Asian descent (8%), followed by African-American (5%) and American Indian or Alaskan Native participants (4%) (see Table 4).

Table 2. Unique Participant Gender

Unique continuing education activity participants (n=204)		Unique experiential activity participants (n=13)		Total unique participants (n=217)	
Female	Male	Female	Male	Female	Male
147 (72%)	57 (28%)	10 (77%)	3 (23%)	157 (72%)	60 (28%)

Table 3. Unique Participant Ethnicity

Unique continuing education activity participants (n=199)		Unique experiential activity participants (n=11)		Total unique participants (n=210)	
Hispanic /Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino
16 (8%)	183 (92%)	2 (18%)	9 (82%)	18 (9%)	192 (91%)

Table 4. Unique Participant Race

Race	Unique continuing education activity participants (n=195)	Unique experiential activity participants (n=12)	Total unique participants (n=207)
American Indian or Alaskan Native	7 (4%)	2 (17%)	9 (4%)
Asian (Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai origin)	10 (5%)	-	10 (5%)
Asian (Any Asian origin other than Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai origin)	6 (3%)	-	6 (3%)
Black or African-American	11 (6%)	-	11 (5%)
White	160 (80%)	9 (75%)	169 (82%)
Unknown	1 (<1%)	1 (8%)	2 (1%)

Continuing Education Activity Participant Demographics

A demographic profile can be created of **continuing education activity participants** – i.e. a profile of all participants who joined continuing education activities during the reporting period, including participation in multiple events. It is important to note that this profile thus includes duplicate information for the same individual if that individual attended multiple continuing education events. However, it serves as a reflection of the extent and scope of the Training Center’s continuing education activities during the reporting period. There were a total of 359 **continuing education activity participants** (see Table 5). Thus, when combined with the 13 **unique experiential activity participants**,

the combined total of all Training Center activity participants for the reporting period, including duplicates, was 372.

Table 5. Total Participants Including Duplicates

Total continuing Education Activity Participants	Unique experiential activity participants	Total activity participants
359	13	372

Total Continuing Education Activity Participant Demographics

The majority of total continuing education activity participants were female (224/74%) (see Table 6). Approximately 9% of training center participants were of Hispanic/Latino origin (see Table 7). Eighteen percent (18%) of total unique participants were racial minorities, the majority of who were of Asian descent (8%), followed by African-American (7%) and American Indian or Alaskan Native participants (3%) (see Table 8).

Table 6. Total Participant Gender

Total continuing education activity participants (n=301)		Unique experiential activity participants (n=13)		Total activity participants (n=314)	
Female	Male	Female	Male	Female	Male
224 (74%)	77 (26%)	10 (77%)	3 (23%)	234 (75%)	80 (25%)

Table 7. Total Participant Ethnicity

Total continuing education activity participants (n=293)		Unique experiential activity participants (n=11)		Total unique participants (n=304)	
Hispanic/Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino
27 (9%)	266 (91%)	2 (18%)	9 (82%)	29 (10%)	275 (90%)

Table 8. Total Participant Race

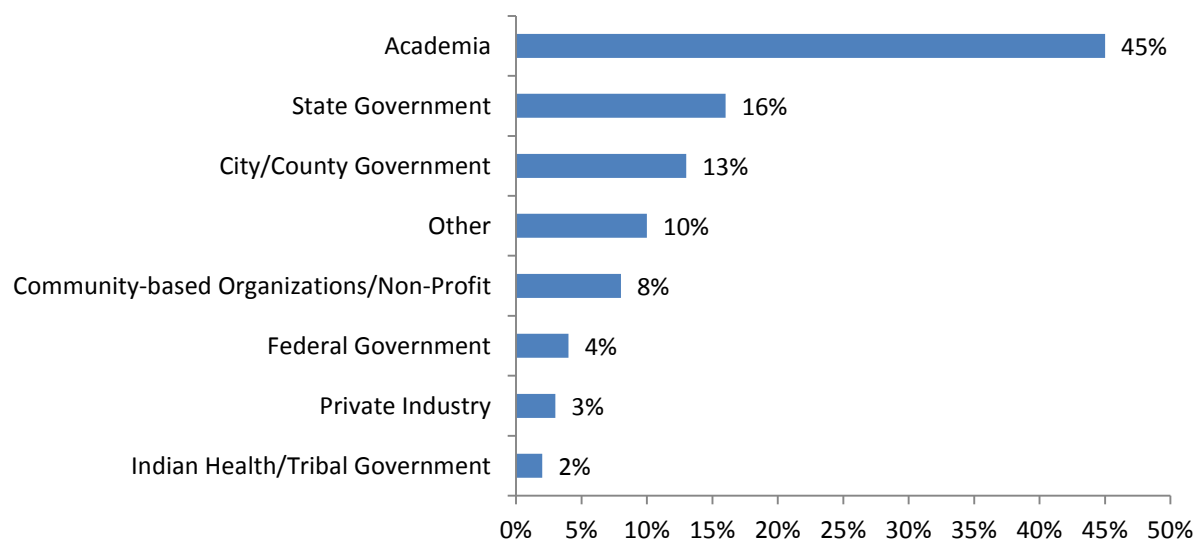
Race	Total continuing education activity participants (n=288)	Unique experiential participants (n=12)	Total unique participants (n=300)
American Indian or Alaskan Native	8 (3%)	2 (17%)	10 (3%)
Asian (Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai origin)	15 (5%)	-	15 (5%)
Asian (Any Asian origin other than Chinese, Filipino, Japanese,	9 (3%)	-	9 (3%)

Korean, Asian Indian, or Thai origin)			
Black or African-American	20 (7%)	-	20 (7%)
White	232 (80%)	9 (75%)	241 (80%)
Unknown	4 (1%)	1 (8%)	5 (2%)

Unique Continuing Education Activity Participants Professional Information

Continuing education activity participants were asked to describe where they were employed, and what their professions were. A total of 182 unique continuing education activity participants responded to the question. The largest segment of respondents, 45%, indicated they worked in academia (n=82) (see Figure 2). This includes both students as well as faculty and/or staff.

Figure 2. Unique Continuing Education Activity Participant Employment Locations



Trainees were also asked what specific professions they were. A total of 197 unique continuing education activity participants responded to this question (see Table 9). The most frequently identified professions were health administration (14%) and health promotion (14%). However, 26% of unique continuing education activity training participants identified their profession as “other”. Of the identified professions in that category, the majority identified their profession as being a student.

Table 9. Unique Continuing Education Activity Participant Professions

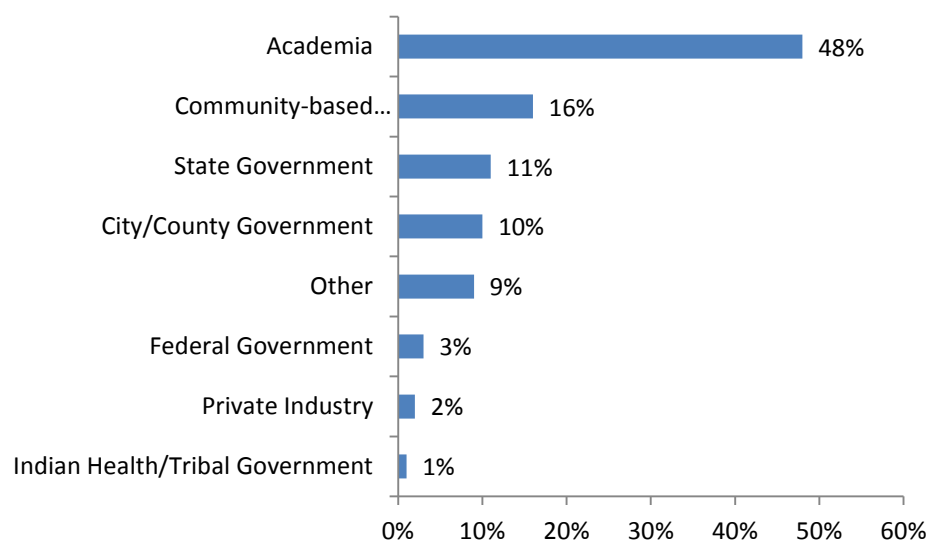
Profession	N=197
Biostatistician	7 (4%)
Community health worker	5 (3%)
Dentist	1 (<1%)
Emergency management/Bioterror/Preparedness	6 (3%)

Environmental health/Sanitarian	5 (3%)
Epidemiology	8 (4%)
Health administration	28 (14%)
Health information systems/Data analyst	1 (<1%)
Health promotion/Education	27 (14%)
Laboratory sciences	2 (1%)
Mental health/Substance abuse	1 (<1%)
Nurse	16 (8%)
Nutritionist/Dietician	1 (<1%)
Physician	7 (4%)
Public Health Law	1 (<1%)
Public Health Policy	9 (5%)
Social Worker	3 (2%)
Support Staff Member	4 (2%)
Teacher/Faculty Member	14 (7%)
Other	51 (26%)

Total Continuing Education Activity Participants Professional Information

Professional information for all continuing education activity participants, including individuals who are counted multiple times, is presented below. Information was collected from 271 activity participants. This profile thus represents the professional backgrounds of all activity participants who participated in continuing education activities (see Figure 3). When asked where they were employed, the largest category was again academia at 130 activity participants or 48%.

Figure 3. Total Continuing Education Activity Participant Employment Locations



A total of 293 continuing education activity participants responded to the question asking them to identify their specific profession (see Table 10). The largest single categories of reported professions were again health promotion/education (15%) and health administration (15%). However, 25% of

activity participants identified their profession as “other”, with the majority of those participants identifying themselves as students.

Table 10. Total Continuing Education Activity Participant Professions

Profession	N=293
Biostatistician	9 (3%)
Community health worker	7 (2%)
Dentist	1 (<1%)
Emergency management/Bioterror/Preparedness	7 (2%)
Environmental health/Sanitarian	9 (3%)
Epidemiology	9 (3%)
Health administration	43 (15%)
Health information systems/Data analyst	2 (<1%)
Health promotion/Education	45 (15%)
Laboratory sciences	2 (<1%)
Mental health/Substance abuse	3 (1%)
Nurse	22 (8%)
Nutritionist/Dietician	2 (<1%)
Physician	9 (3%)
Public Health Law	1 (<1%)
Public Health Policy	13 (4%)
Social Worker	3 (1%)
Support Staff Member	9 (3%)
Teacher/Faculty Member	19 (7%)
Other	73 (25%)

Experiential Trainees

There were a total of 13 **unique experiential activity participants** who enrolled in Training Center activities during the reporting period. Eleven individuals enrolled as field placement students, and interned at participating local field placement sites throughout the state. One field placement intern later dropped out. Two individuals enrolled in collaborative projects during the first reporting period. An overview of participant background data is presented below in Table 11. Pre-Training Center core competency data is presented in tables 22-31 below.

Table 11. Experiential Trainees

Total Entering Class, 2011	13 (12 after drop-out)
Gender	
Female	10 (83%)
Male	2 (17%)
Race	
American Indian or Alaskan Native	1 (8%)

Asian or Pacific Islander	
Black or African-American	
White	9 (75%)
Unknown	1 (8%)
More than one race	1 (8%)
Ethnicity	
Hispanic or Latino	2 (17%)
Non-Hispanic or Latino	10 (83%)
Current Employment Background	
Employed in Rural Areas	6 (50%)
Employed in Medically Underserved Areas	4 (33%)

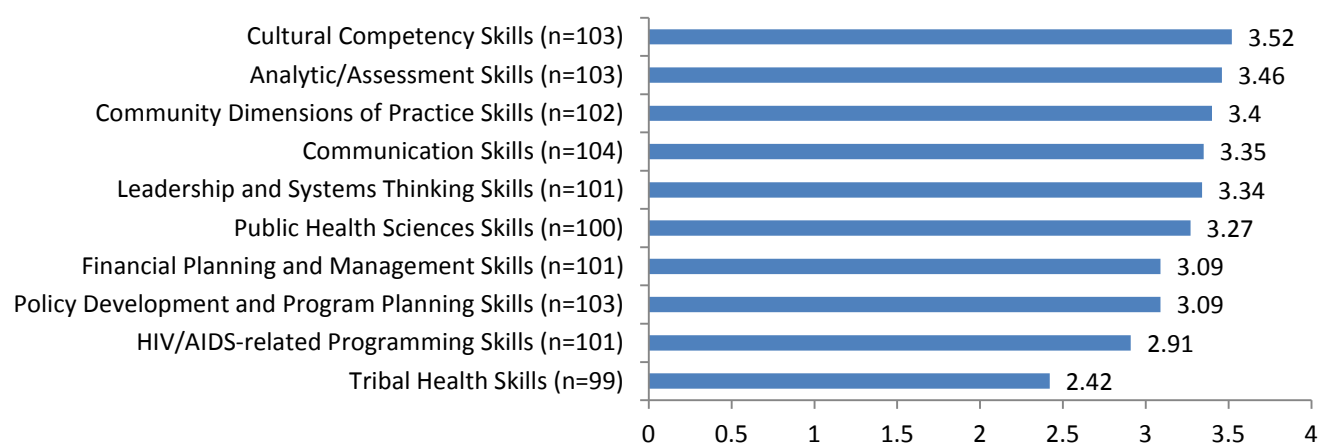
Self-Assessment of Participant Competencies, Total Unique Participants

For total unique participants (n=220), a mean score was derived of the sum of all self-assessed ratings on the public health core competencies, on a level of 1-5 with 1="low" and 5="high". In addition to the public health core competency domains, we also calculated the average self-assessment score for HIV/AIDS-related programming skills and tribal health-related skills on the same 1-5 scale.

Overall Domain Average

The average domain score represents the self-assessed skill levels of each of these domains among the total unique participants. The domain with the highest self-assessed average skill level was cultural competency skills at 3.52, and the lowest was tribal health skills at 2.42 (see Figure 4). It should be noted that this information was collected among all unique participants immediately prior to their beginning training center activities. It thus represents their skill levels prior to having participated in the training center. A one-year post event assessment will be calculated at a later point to determine whether self-assessed skills have changed.

Figure 4. All Participants - Overall Skills



Individual Competencies

We calculated means of self-assessed skills levels for each individual public health core competency and HIV/AIDS-related and tribal health domains across all unique participants. Mean scores for individual competencies are presented in Table 12-21 below.

Table 12. All Participants – Analytic/Assessment Skills

Analytic/Assessment Skills Overall Domain Mean (n=103)	3.46
Identify the health status of populations and their related determinants of health and illness	3.42
Describe the characteristics of a population-based health problem	3.48
Use variables that measure public health conditions	3.26
Use methods and instruments for collecting valid and reliable quantitative and qualitative data	3.32
Identify sources of public health data and information	3.61
Recognize the integrity and comparability of data	3.39
Identify gaps in data sources	3.27
Adhere to the application of ethical principles in the collection, maintenance, use, and dissemination of data and information	3.74
Describe the public health applications of quantitative and qualitative data and collects quantitative and qualitative community data	3.38
Use information technology to collect, store, and retrieve data	3.53
Describe data to address the scientific, political, ethical, and social public health issues	3.62

Table 13. All Participants - Policy Development and Program Planning Skills

Policy Development and Program Planning Skills Overall Domain Mean (n=103)	3.09
Gather information relevant to specific public health policy issues	3.49
Describe how policy options can influence public health programs	3.09
Explain the expected outcomes of policy options	3.02
Gather information that will inform policy decisions	3.37
Describe the public health laws and regulations governing public health programs	2.71
Participate in program planning processes	3.25
Incorporate policies and procedures into program plans and structures	3.1
Identify mechanisms to monitor and evaluate programs for their effectiveness and quality	2.98
Demonstrate the use of public health informatics practices and procedures	2.85
Apply strategies for continuous quality improvement	3.09

Table 14. All Participants - Communication Skills

Communication Skills Overall Domain Mean (n=104)	3.35
Identify the health literacy of populations served	2.92
Communicate in writing and orally, in person, and through electronic means, with linguistic and cultural proficiency	3.61
Solicit community-based input from individuals and organizations	3.42
Convey public health information through a variety of approaches	3.41

Participate in the development of demographic, statistical, programmatic, and scientific presentations	3.46
Apply communication and group dynamic strategies in interactions with individuals and groups	3.35

Table 15. All Participants - Cultural Competency Skills

Cultural Competency Skills Overall Domain Mean (n=103)	3.52
Incorporate strategies for interacting with persons from diverse backgrounds	3.56
Recognize the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability, and delivery of public health services	3.74
Respond to diverse needs that are the result of cultural differences	3.4
Describe the dynamic forces that contribute to cultural diversity	3.47
Describe the need for a diverse public health workforce	3.64
Participate in the assessment of the cultural competence of the public health organization	3.37

Table 16. All Participants - Community Dimensions of Practice Skills

Community Dimensions of Practice Skills Overall Domain Mean (n=102)	3.4
Recognize community linkages and relationships among multiple factors (or determinants) affecting health	3.48
Demonstrate the capacity to work in community-based participatory research efforts	3.33
Identify stakeholders	3.28
Collaborate with community partners to promote the health of the population	3.61
Maintain partnerships with key stakeholders	3.42
Use group processes to advance community involvement	3.35
Describe the role of governmental and non-governmental organizations in the delivery of community health services	3.28
Identify community assets and resources	3.42
Gather input from the community to inform the development of public health policy and programs	3.34
Inform the public about policies, programs, and resources	3.46

Table 17. All Participants - Public Health Science Skills

Public Health Science Skills Overall Domain Mean (n=100)	3.27
Describe the scientific foundation of the field of public health	3.26
Identify prominent events in the history of the public health profession	3.19
Relate public health science skills to the Core Public Health Functions and the Ten Essential Services	2.88
Identify the basic public health sciences (including, but not limited to biostatistics, epidemiology, environmental health sciences, health services administration, and social and behavioral health sciences)	3.32
Describe the scientific evidence related to a public health issue, concern, or intervention	3.32
Retrieve scientific evidence related to a public health issue, concern, or intervention	3.43
Discuss the limitations of research findings	3.49

Describe the laws, regulations, policies and procedures for the ethical conduct of research	3.22
Partner with other public health professionals in building the scientific base of public health	3.28

Table 18. All Participants - Financial Planning and Management Skills

Financial Planning and Management Skills Overall Domain Mean (n=101)	3.09
Describe the local, state, and federal public health and health care systems	2.97
Describe the organizational structures, functions, and authorities of local, state, and federal public health agencies	2.95
Adhere to the organization's policies and procedures	3.46
Participate in the development of programmatic budget	2.96
Operate programs within current and forecasted budget constraints	3.02
Identify strategies for determining budget priorities based on federal, state, and local financial contributions	2.99
Report program performance	3.29
Translate evaluation report information into program performance improvement action steps	3.05
Contribute to the preparation of proposals for funding from external sources	3.27
Apply basic human relations skills to internal collaborations, motivation of colleagues, and resolutions of conflicts	3.48
Demonstrate public health informatics skills to improve program and business operations	2.8
Participate in the development of contracts and other agreements for the provision of services	2.99
Describe how cost-effectiveness, cost-benefit, and cost-utility analyses affect programmatic prioritization and decision-making	2.83

Table 19. All Participants – Leadership and Systems Thinking Skills

Leadership and Systems Thinking Skills Overall Domain Mean (n=101)	3.34
Incorporate ethical standards of practice as the basis of all interactions with organizations, communities, and individuals	3.56
Describe how public health operates within a larger system	3.39
Participate with stakeholders in identifying key public health values and a shared public health vision as guiding principles for community action	3.28
Identify internal and external problems that may affect the delivery of Essential Public Health Services	3.25
Use individual, team, and organizational learning opportunities for personal and professional development	3.45
Participate in mentoring and peer review or coaching opportunities	3.43
Participate in the measuring, reporting, and continuous improvement of organizational performance	3.22
Describe the impact of changes in the public health system and the larger social, political, or economic environment on organizational practices	3.19

Table 20. All Participants - HIV/AIDS-related Programming Skills

HIV/AIDS-related Programming Skills Overall Domain Mean (n=101)	2.91
Discuss HIV/AIDS related diagnosis and treatment issues with community members you serve	2.78
Address stigma issues related to HIV/AIDS within communities you serve	2.98
Properly refer individuals to further information or services for HIV/AIDS	2.97

Table 21. All Participants - Tribal Health Skills

Tribal Health Skills Overall Domain Mean (n=99)	2.42
Identify and understand jurisdictional issues involving tribes that may impact delivery of public health services.	2.39
Identify and understand policies that may impact public health among tribal populations.	2.49
Effectively gather data to monitor public health issues affecting tribal populations in Nebraska.	2.38
Implement evidence-based best practices in public health specifically tailored for tribal populations.	2.41

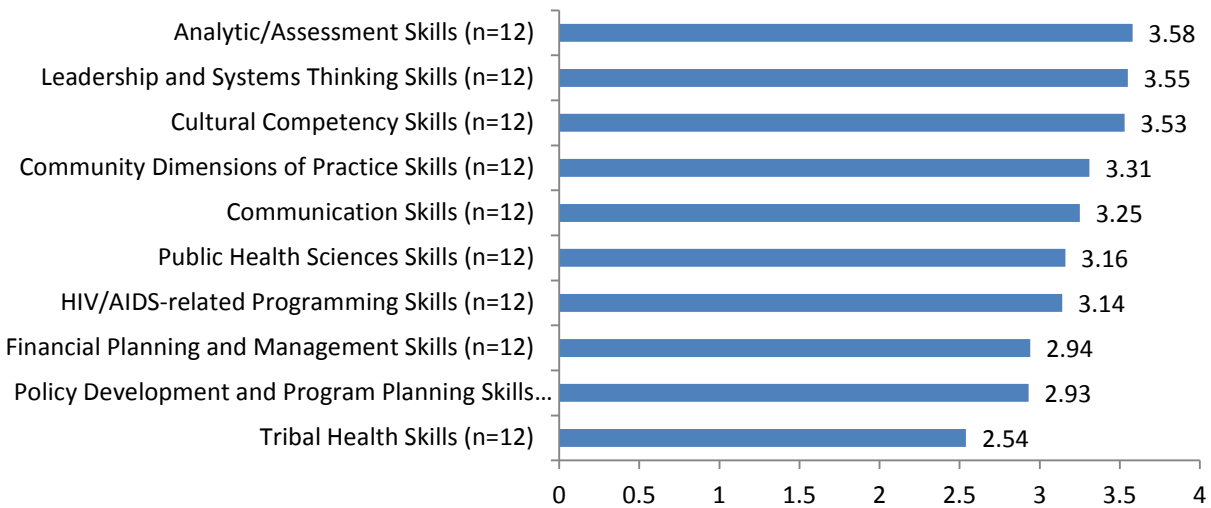
Self-Assessment of Participant Competencies, Experiential Participants

For unique experiential participants (n=12), a mean score was derived of the sum of all self-assessed ratings on the public health core competencies, on a level of 1-5 with 1="low" and 5="high". In addition to the public health core competency domains, we also calculated the average self-assessment score for HIV/AIDS-related programming skills and tribal health-related skills on the same 1-5 scale.

Overall Domain Average

The average domain score represents the self-assessed skill levels of each of these domains among the unique experiential participants. The domain with the highest self-assessed average skill level was analytic/assessment skills at 3.58, and the lowest was tribal health skills at 2.54 (see Figure 5). It should be noted that this information was collected among experiential participants prior to their beginning field placement and collaborative project experiences. It thus represents their skill levels prior to having participated in the training center. A post-experience assessment and a one-year post training assessment will be calculated to determine whether self-assessed skills have changed.

Figure 5. Experiential Participants - Overall Skills



Individual Competencies

We calculated means of self-assessed skills levels for each individual public health core competency and HIV/AIDS-related and tribal health domains across all experiential participants. Mean scores for individual competencies are presented below in tables 22-31.

Table 22. Experiential Participants – Analytic/Assessment Skills

Analytic/Assessment Skills Overall Domain Mean (n=12)	3.18
Identify the health status of populations and their related determinants of health and illness	3.08
Describe the characteristics of a population-based health problem	3.00
Use variables that measure public health conditions	2.75
Use methods and instruments for collecting valid and reliable quantitative and qualitative data	3.00
Identify sources of public health data and information	3.25
Recognize the integrity and comparability of data	2.92
Identify gaps in data sources	3.17
Adhere to the application of ethical principles in the collection, maintenance, use, and dissemination of data and information	3.58
Describe the public health applications of quantitative and qualitative data and collects quantitative and qualitative community data	3.08
Use information technology to collect, store, and retrieve data	3.58
Describe data to address the scientific, political, ethical, and social public health issues	3.58

Table 23. Experiential Participants - Policy Development and Program Planning Skills

Policy Development and Program Planning Skills Overall Domain Mean (n=12)	2.93
Gather information relevant to specific public health policy issues	3.58
Describe how policy options can influence public health programs	3.08

Explain the expected outcomes of policy options	3.00
Gather information that will inform policy decisions	3.25
Describe the public health laws and regulations governing public health programs	2.33
Participate in program planning processes	3.25
Incorporate policies and procedures into program plans and structures	3.08
Identify mechanisms to monitor and evaluate programs for their effectiveness and quality	2.67
Demonstrate the use of public health informatics practices and procedures	2.42
Apply strategies for continuous quality improvement	2.67

Table 24. Experiential Participants - Communication Skills

Communication Skills Overall Domain Mean (n=12)	3.25
Identify the health literacy of populations served	3.17
Communicate in writing and orally, in person, and through electronic means, with linguistic and cultural proficiency	3.42
Solicit community-based input from individuals and organizations	3.17
Convey public health information through a variety of approaches	3.25
Participate in the development of demographic, statistical, programmatic, and scientific presentations	3.33
Apply communication and group dynamic strategies in interactions with individuals and groups	3.17

Table 25. Experiential Participants - Cultural Competency Skills

Cultural Competency Skills Overall Domain Mean (n=12)	3.53
Incorporate strategies for interacting with persons from diverse backgrounds	3.5
Recognize the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability, and delivery of public health services	3.58
Respond to diverse needs that are the result of cultural differences	3.42
Describe the dynamic forces that contribute to cultural diversity	3.58
Describe the need for a diverse public health workforce	3.58
Participate in the assessment of the cultural competence of the public health organization	3.5

Table 26. Experiential Participants - Community Dimensions of Practice Skills

Community Dimensions of Practice Skills Overall Domain Mean (n=12)	3.31
Recognize community linkages and relationships among multiple factors (or determinants) affecting health	3.58
Demonstrate the capacity to work in community-based participatory research efforts	3.42
Identify stakeholders	2.92
Collaborate with community partners to promote the health of the population	3.42
Maintain partnerships with key stakeholders	3.25
Use group processes to advance community involvement	3.17
Describe the role of governmental and non-governmental organizations in the delivery of community health services	3.08
Identify community assets and resources	3.42

Gather input from the community to inform the development of public health policy and programs	3.33
Inform the public about policies, programs, and resources	3.5

Table 27. Experiential Participants - Public Health Science Skills

Public Health Science Skills Overall Domain Mean (n=12)	3.16
Describe the scientific foundation of the field of public health	3.25
Identify prominent events in the history of the public health profession	2.83
Relate public health science skills to the Core Public Health Functions and the Ten Essential Services	2.42
Identify the basic public health sciences (including, but not limited to biostatistics, epidemiology, environmental health sciences, health services administration, and social and behavioral health sciences)	3.25
Describe the scientific evidence related to a public health issue, concern, or, intervention	3.25
Retrieve scientific evidence related to a public health issue, concern, or intervention	3.42
Discuss the limitations of research findings	3.58
Describe the laws, regulations, policies and procedures for the ethical conduct of research	3.17
Partner with other public health professionals in building the scientific base of public health	3.25

Table 28. Experiential Participants - Financial Planning and Management Skills

Financial Planning and Management Skills Overall Domain Mean (n=12)	2.94
Describe the local, state, and federal public health and health care systems	2.75
Describe the organizational structures, functions, and authorities of local, state, and federal public health agencies	2.83
Adhere to the organization's policies and procedures	3.33
Participate in the development of programmatic budget	2.92
Operate programs within current and forecasted budget constraints	2.83
Identify strategies for determining budget priorities based on federal, state, and local financial contributions	2.75
Report program performance	2.92
Translate evaluation report information into program performance improvement action steps	3.00
Contribute to the preparation of proposals for funding from external sources	3.00
Apply basic human relations skills to internal collaborations, motivation of colleagues, and resolutions of conflicts	3.42
Demonstrate public health informatics skills to improve program and business operations	2.83
Participate in the development of contracts and other agreements for the provision of services	2.92
Describe how cost-effectiveness, cost-benefit, and cost-utility analyses affect programmatic prioritization and decision-making	2.75

Table 29. Experiential Participants - Leadership and Systems Thinking Skills

Leadership and Systems Thinking Skills Overall Domain Mean (n=12)	3.55
Incorporate ethical standards of practice as the basis of all interactions with organizations, communities, and individuals	3.5
Describe how public health operates within a larger system	3.42
Participate with stakeholders in identifying key public health values and a shared public health vision as guiding principles for community action	3.17
Identify internal and external problems that may affect the delivery of Essential Public Health Services	3.33
Use individual, team, and organizational learning opportunities for personal and professional development	3.92
Participate in mentoring and peer review or coaching opportunities	4
Participate in the measuring, reporting, and continuous improvement of organizational performance	3.58
Describe the impact of changes in the public health system and the larger social, political, or economic environment on organizational practices	3.5

Table 30. Experiential Participants - HIV/AIDS-related Programming Skills

HIV/AIDS-related Programming Skills Overall Domain Mean (n=12)	3.14
Discuss HIV/AIDS related diagnosis and treatment issues with community members you serve	2.83
Address stigma issues related to HIV/AIDS within communities you serve	3.42
Properly refer individuals to further information or services for HIV/AIDS	3.17

Table 31. Experiential Participants - Tribal Health Skills

Tribal Health Skills Overall Domain Mean (n=12)	2.54
Identify and understand jurisdictional issues involving tribes that may impact delivery of public health services.	2.42
Identify and understand policies that may impact public health among tribal populations.	2.75
Effectively gather data to monitor public health issues affecting tribal populations in Nebraska.	2.5
Implement evidence-based best practices in public health specifically tailored for tribal populations.	2.5

Post-Training Activity Assessments

Post-activity surveys asked Training Center **continuing education** participants to assess their perceptions of training activities, including their perceived impact on knowledge (see figures 6-15), whether they would recommend the training activity to colleagues (see figures 16-22), perceptions of training activity length (see figures 23-29), perceptions of training information adequacy (see figures 30-36), and

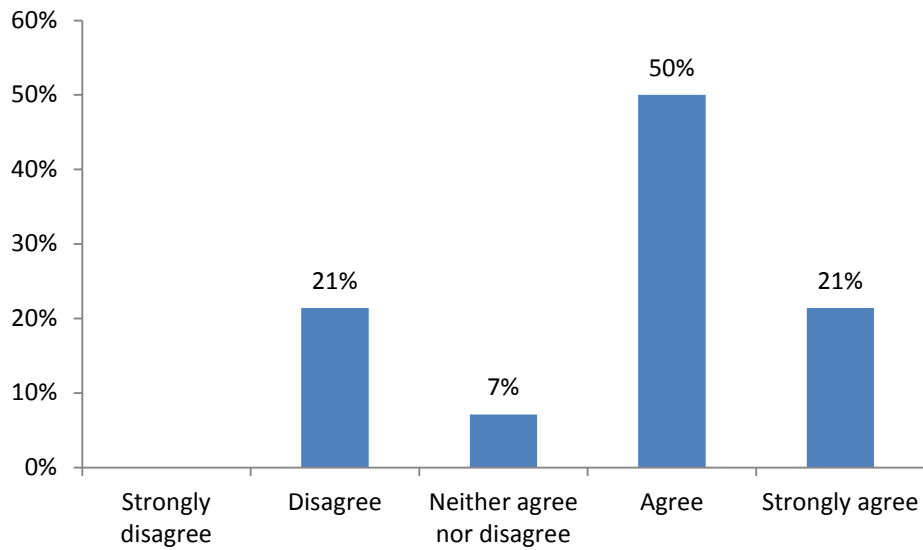
perceptions of training activity difficulty (see figures 37-43). That information is presented per training activity, as well as in aggregate form.

Continuing Education: Post-Event Knowledge Gain

November 16, 2011: Leadership Training and Conflict Mining Workshop, Part I.

71% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=14).

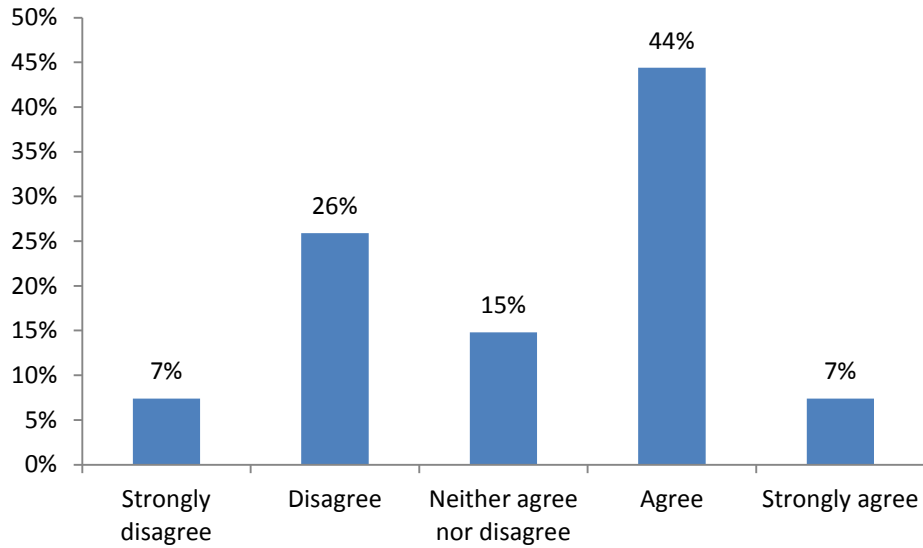
Figure 6. Knowledge Increase. November 16, 2011: Conflict Mining Workshop, Part I.



January 20, 2012: University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Georges Benjamin.

51% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=27).

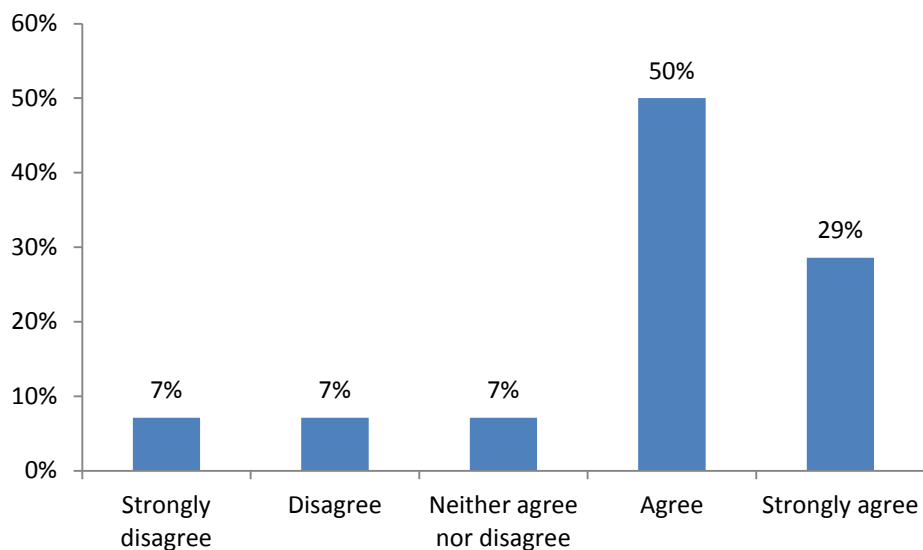
Figure 7. Knowledge Increase. January 20, 2012: Dr. Georges Benjamin.



January 26, 2012: Leadership Training and Conflict Mining Workshop, Part II.

79% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=14).

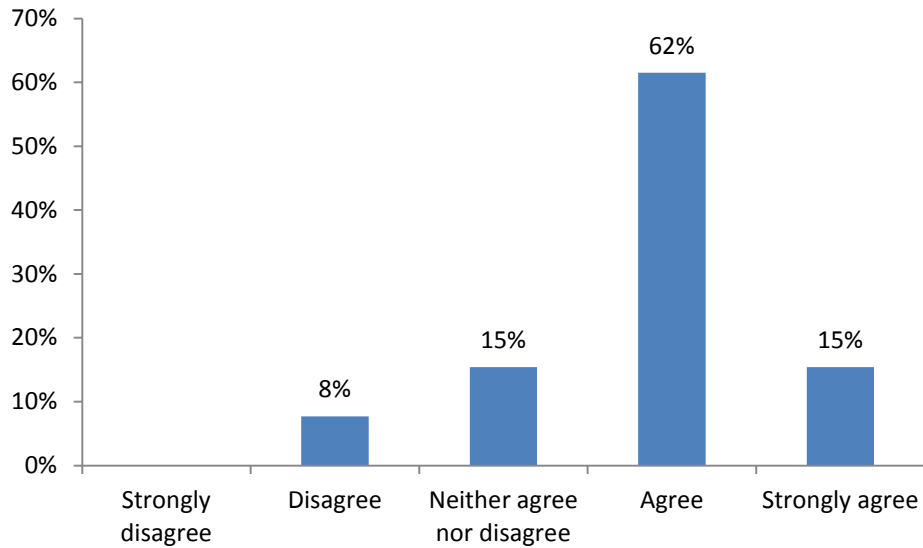
Figure 8. Knowledge Increase. January 26, 2012: Conflict Mining Workshop, Part II.



March 8, 2012: The Challenges We Face, the Leaders We Need - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Fraser.

77% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=13).

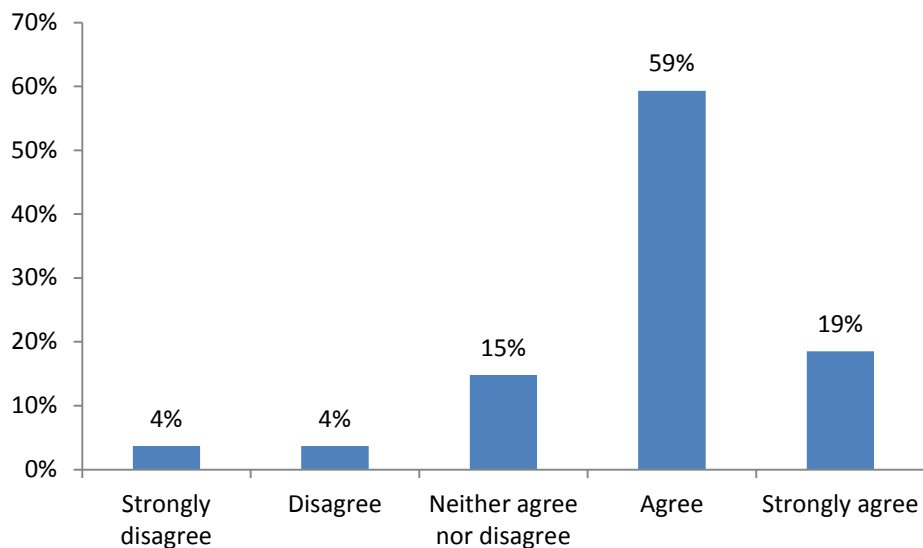
Figure 9. Knowledge Increase. March 8, 2012: Dr. Michael Fraser.



April 2, 2012: National Public Health Week: Community Kick-off Events

78% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=27).

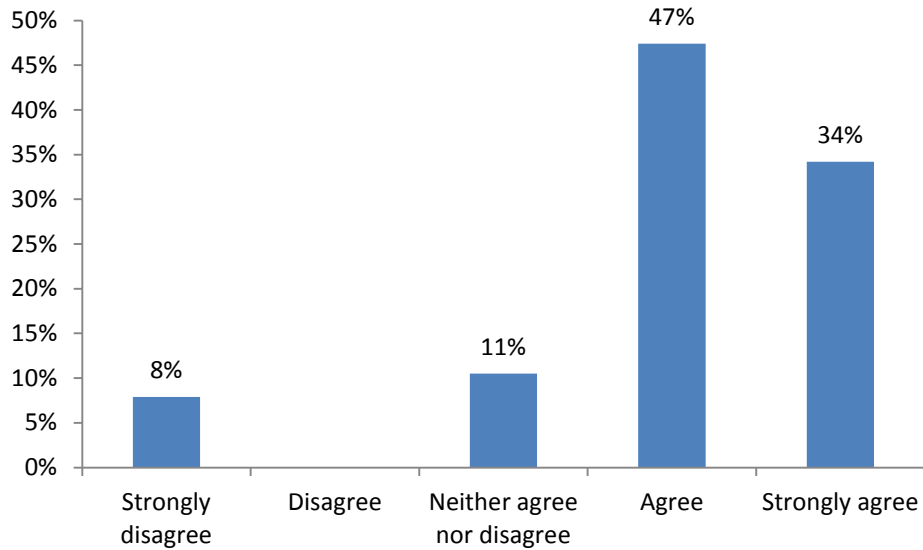
Figure 10. Knowledge Increase. April 2, 2012: National Public Health Week



April 6, 2012: Behavioral Health: Why It Matters to Public Health and What to Do About It - University of Nebraska Medical Center Leadership Speaker Series, featuring Laura Howard.

81% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=38).

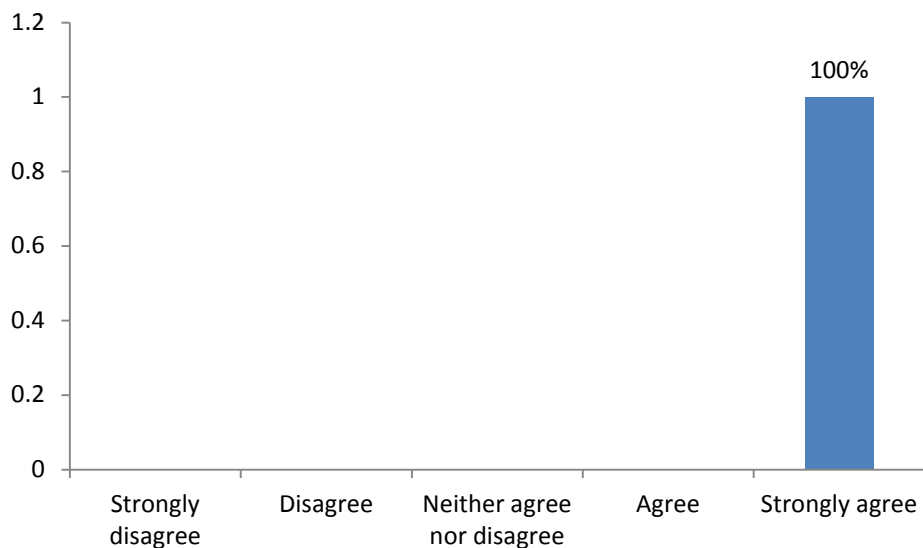
Figure 11. Knowledge Increase. April 6, 2012: Laura Howard.



June 19, 2012: 7th Annual Tribal Leader/Scholar Program at the National Congress of American Indians' Mid-Year Conference.

100% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=2).

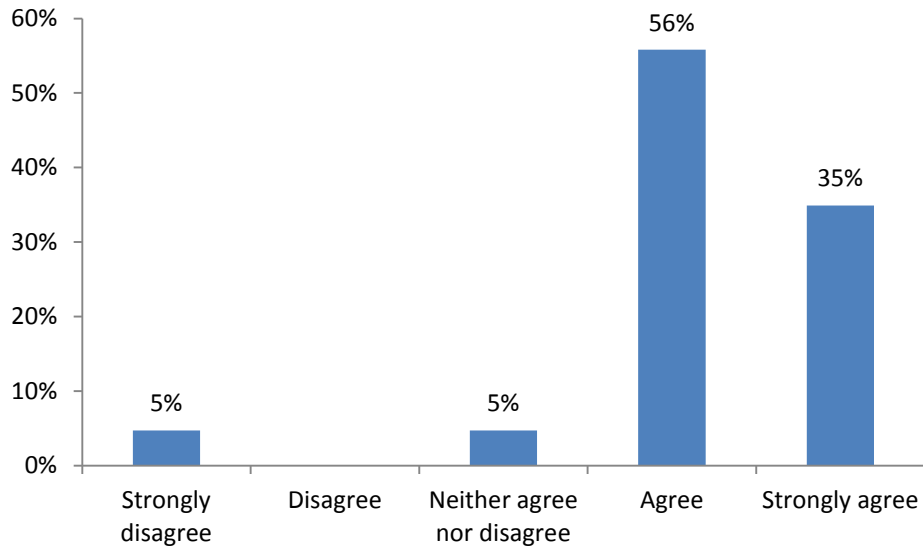
Figure 12. Knowledge Increase. June 19, 2012: 7th Annual Tribal Leader/Scholar Program



June 20, 2012: Nebraska Sexual Health Research in the 21st Century: Innovations and Future Directions - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Reece.

91% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=43).

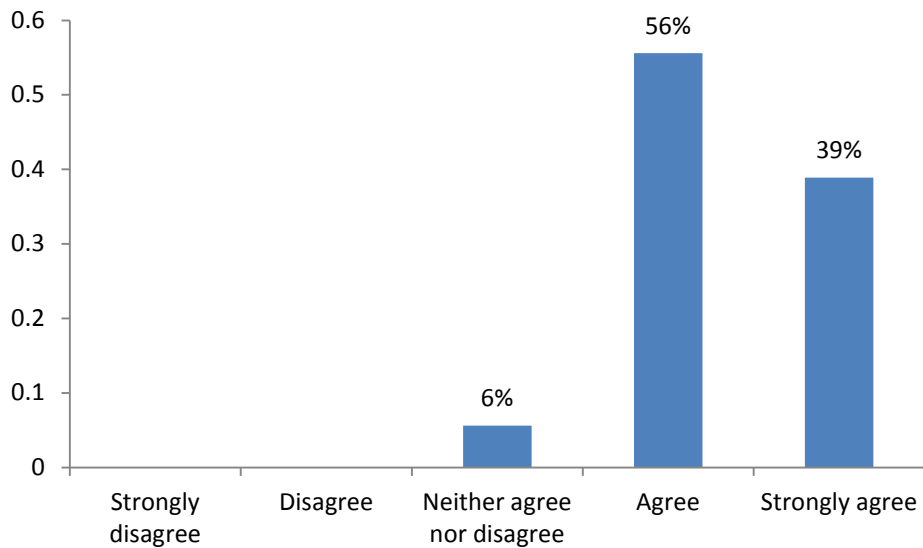
Figure 13. Knowledge Increase. June 20, 2012: Dr. Michael Reece.



June 21, 2012: The Waponahki Tribal Health Assessment: A multi-tribal collaboration between members of the Waponahki Confederacy and the University of Nebraska Medical Center, College of Public Health, featuring Patricia Knox-Nicola.

95% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=18).

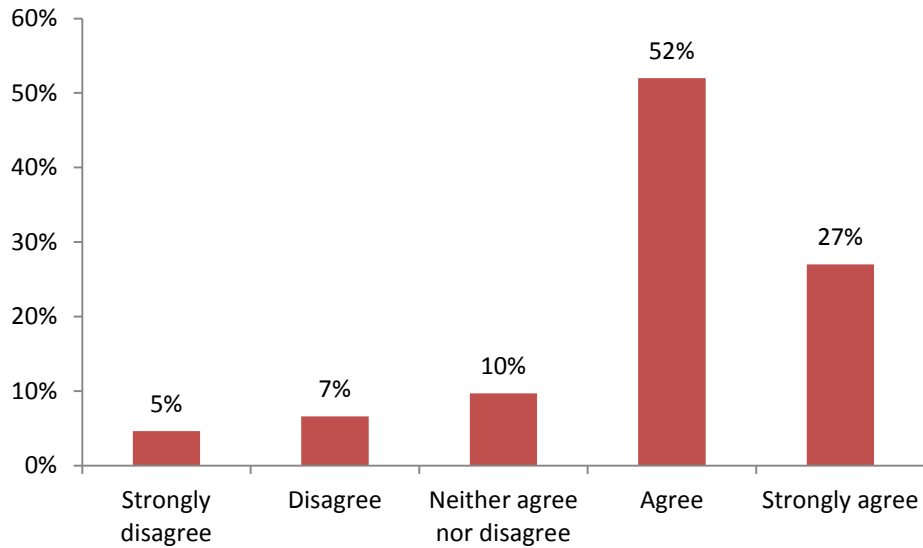
Figure 14. Knowledge Increase. June 21, 2012: Patricia Knox-Nicola.



All Events July 1, 2011 to June 30, 2012

79% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following their participation in training events (n=196).

Figure 15. Knowledge Increase. All Events July 1, 2011 to June 30, 2012

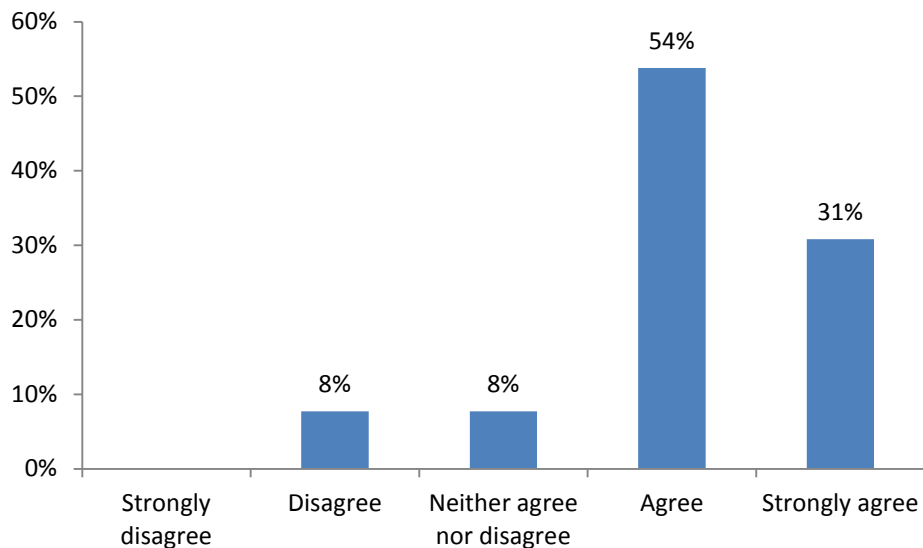


Continuing Education: Post-Event Recommendations of Training

March 8, 2012: The Challenges We Face, the Leaders We Need - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Fraser.

85% of respondents agreed or strongly agreed that they would recommend this training event to others in their profession (n=13).

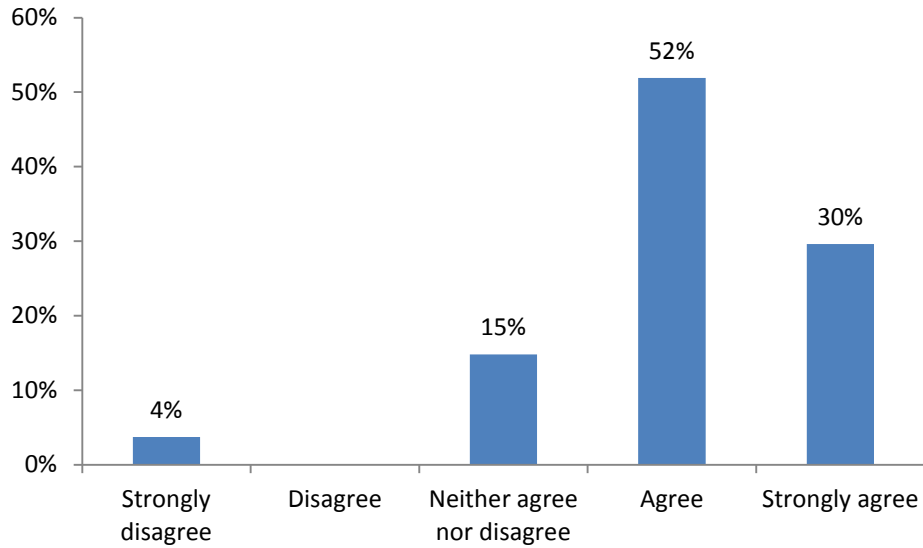
Figure 16. Training Recommendations. March 8, 2012: Dr. Michael Fraser.



April 2, 2012: National Public Health Week: Community Kick-off Events

82% of respondents agreed or strongly agreed that that they would recommend this training event to others in their profession (n=27).

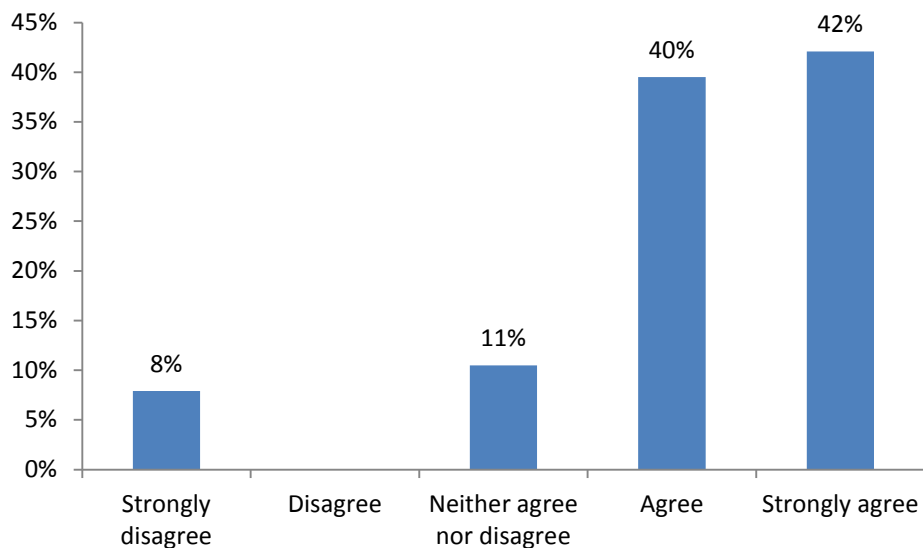
Figure 17. Training Recommendations. April 2, 2012: National Public Health Week



April 6, 2012: Behavioral Health: Why It Matters to Public Health and What to Do About It - University of Nebraska Medical Center Leadership Speaker Series, featuring Laura Howard.

82% of respondents agreed or strongly agreed that that they would recommend this training event to others in their profession (n=38).

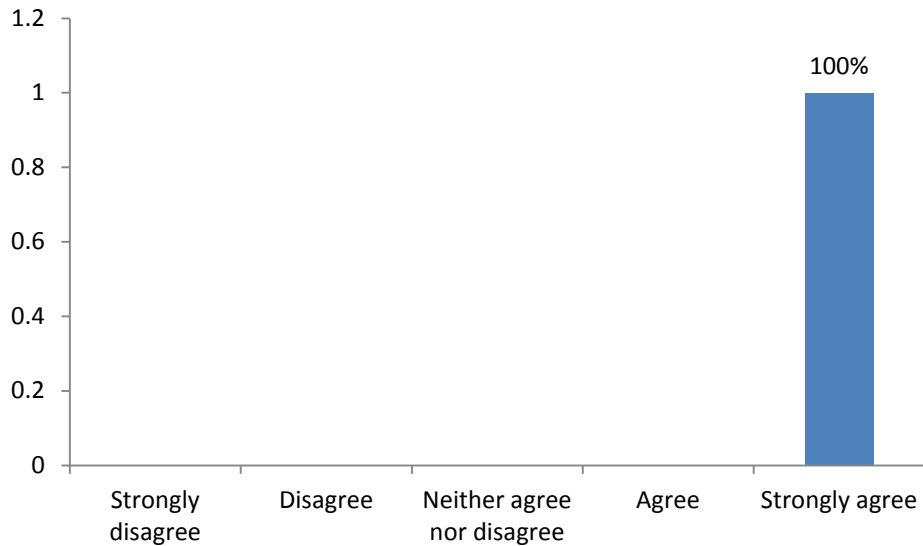
Figure 18. Training Recommendations. April 6, 2012: Laura Howard.



June 19, 2012: 7th Annual Tribal Leader/Scholar Program at the National Congress of American Indians' Mid-Year Conference.

100% of respondents agreed or strongly agreed that they would recommend this training event to others in their profession (n=2).

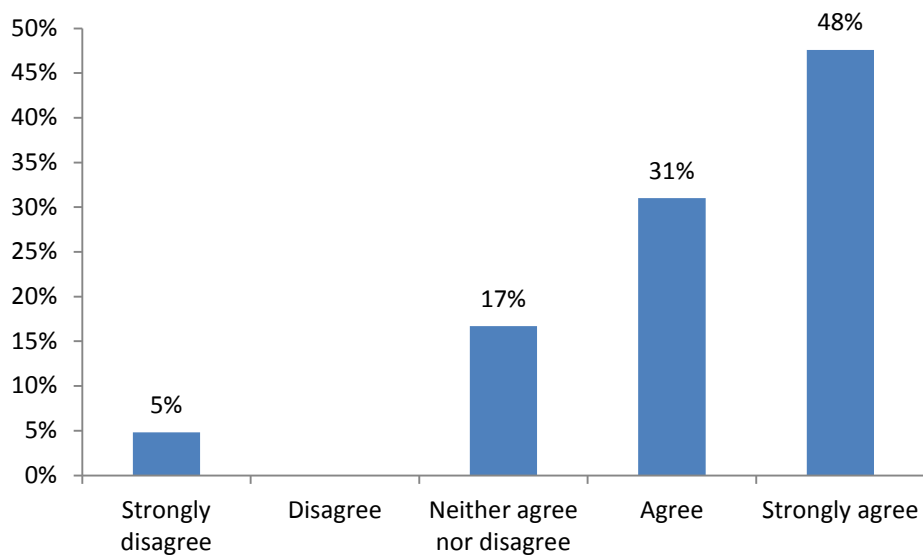
Figure 19. Training Recommendations. June 19, 2012: 7th Annual Tribal Leader/Scholar Program



June 20, 2012: Nebraska Sexual Health Research in the 21st Century: Innovations and Future Directions - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Reece.

79% of respondents agreed or strongly agreed that they would recommend this training event to others in their profession (n=42).

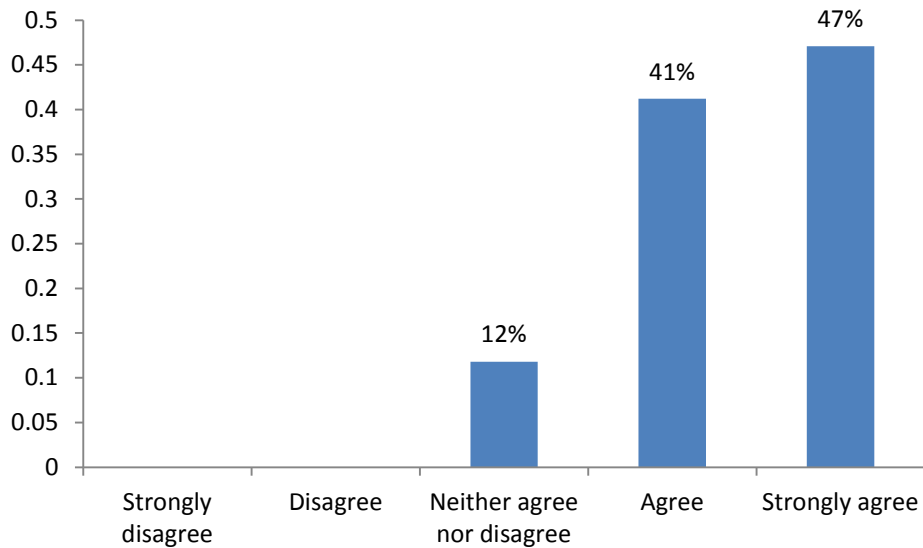
Figure 20. Training Recommendations. June 20, 2012: Dr. Michael Reece.



June 21, 2012: The Waponahki Tribal Health Assessment: A multi-tribal collaboration between members of the Waponahki Confederacy and the University of Nebraska Medical Center, College of Public Health, featuring Patricia Knox-Nicola.

88% of respondents agreed or strongly agreed that they would recommend this training event to others in their profession (n=17).

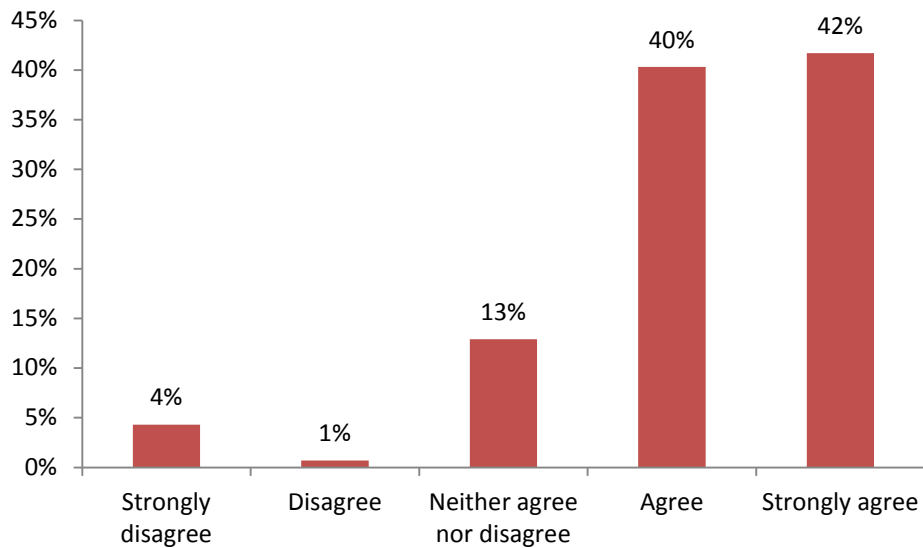
Figure 21. Training Recommendations. June 21, 2012: Patricia Knox-Nicola.



All Events March 8, 2011 to June 30, 2012

82% of respondents agreed or strongly agreed that they would recommend training events they attended to others in their profession (n=139).

Figure 22. Training Recommendations. All Events March 8, 2011 to June 30, 2012

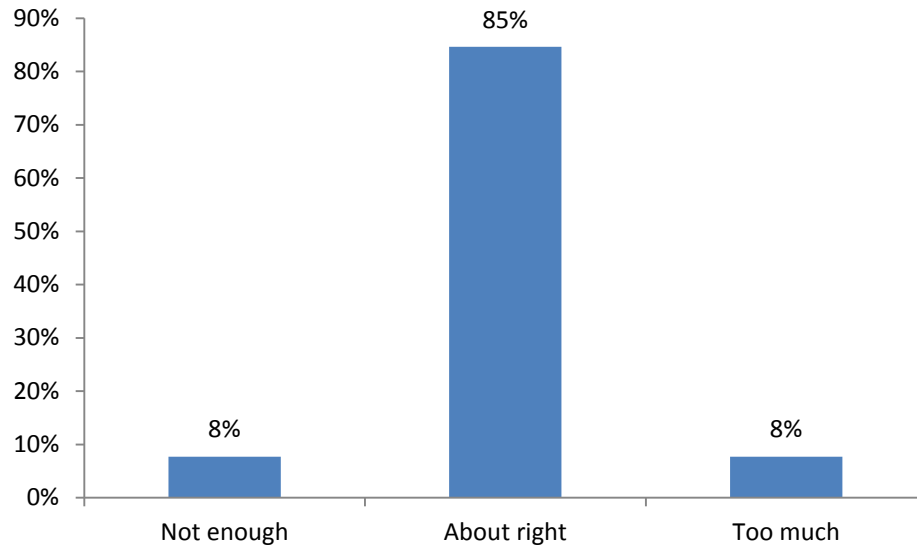


Continuing Education: Post-Event Perceptions of Training Length

March 8, 2012: The Challenges We Face, the Leaders We Need - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Fraser.

85% of respondents believed the length of the training was about right. 8% believed the training was too short and another 8% believed it was too long (n=13).

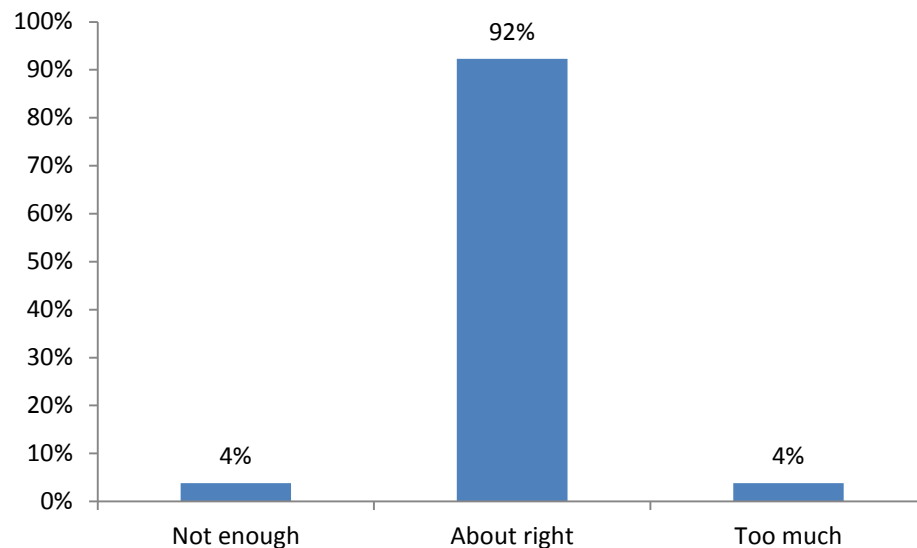
Figure 23. Training Length. March 8, 2012: Dr. Michael Fraser.



April 2, 2012: National Public Health Week: Community Kick-off Events

92% of respondents believed the length of the training was about right. 4% believed the training was too short and another 4% believed it was too long (n=26).

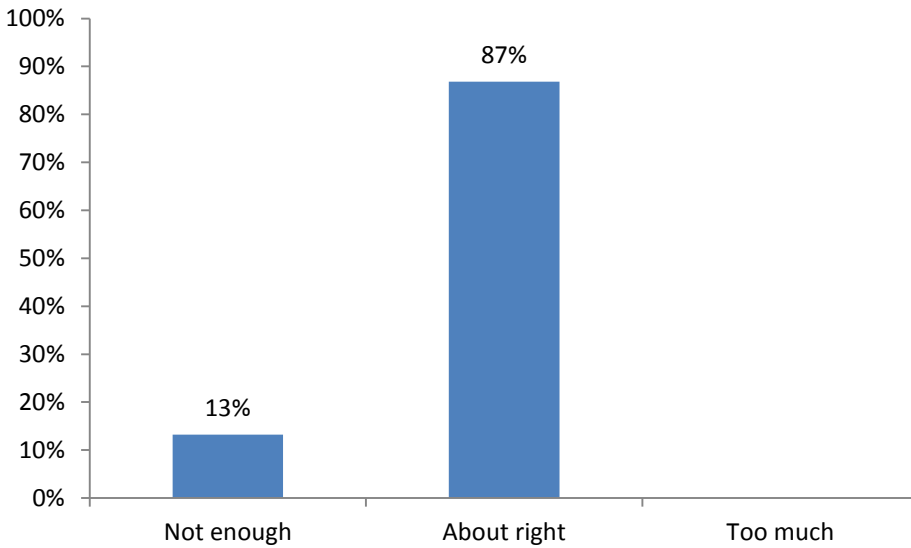
Figure 24. Training Length. April 2, 2012: National Public Health Week



April 6, 2012: Behavioral Health: Why It Matters to Public Health and What to Do About It - University of Nebraska Medical Center Leadership Speaker Series, featuring Laura Howard.

87% of respondents believed the length of the training was about right. 13% believed the training was too short (n=38).

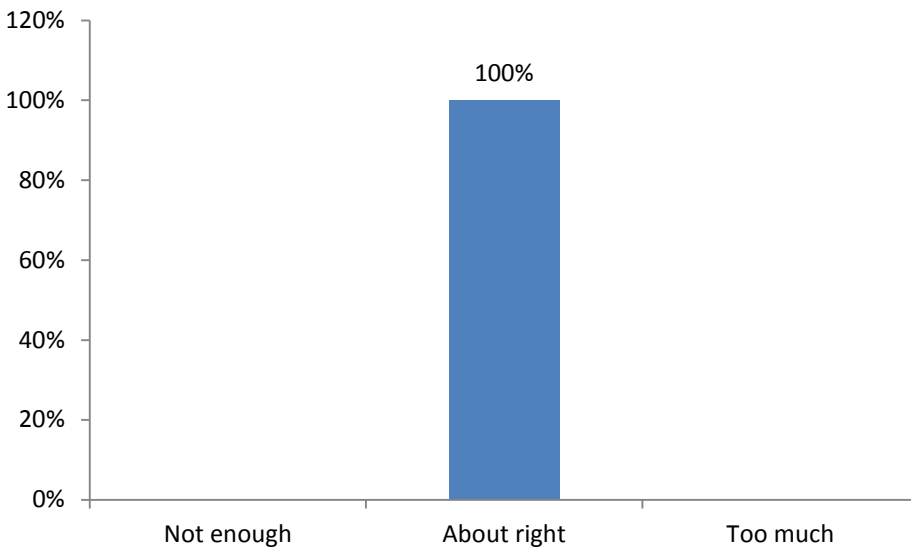
Figure 25. Training Length. April 6, 2012: Laura Howard.



June 19, 2012: 7th Annual Tribal Leader/Scholar Program at the National Congress of American Indians' Mid-Year Conference.

100% of respondents believed the length of the training was about right. 13% believed the training was too short (n=2).

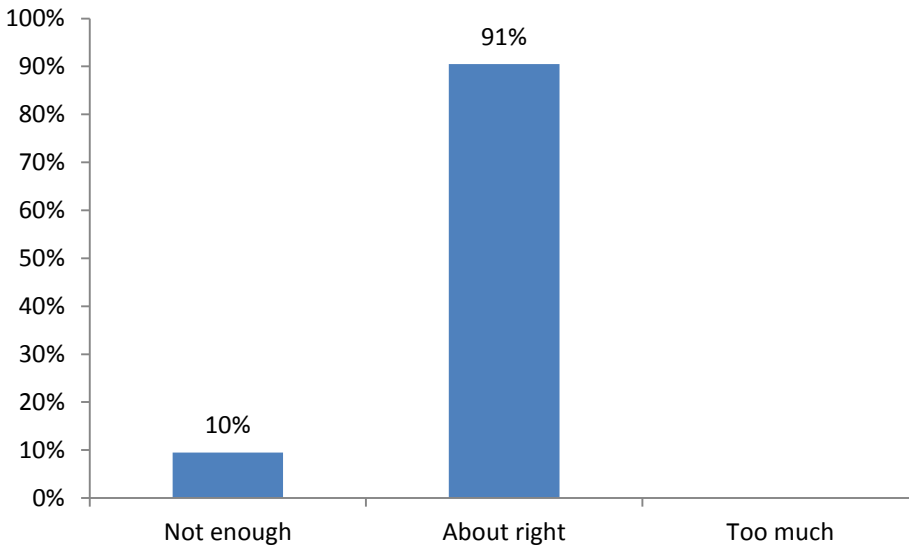
Figure 26. Training Length. June 19, 2012: 7th Annual Tribal Leader/Scholar Program



June 20, 2012: Nebraska Sexual Health Research in the 21st Century: Innovations and Future Directions - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Reece.

91% of respondents believed the length of the training was about right. 10% believed the training was too short (n=42).

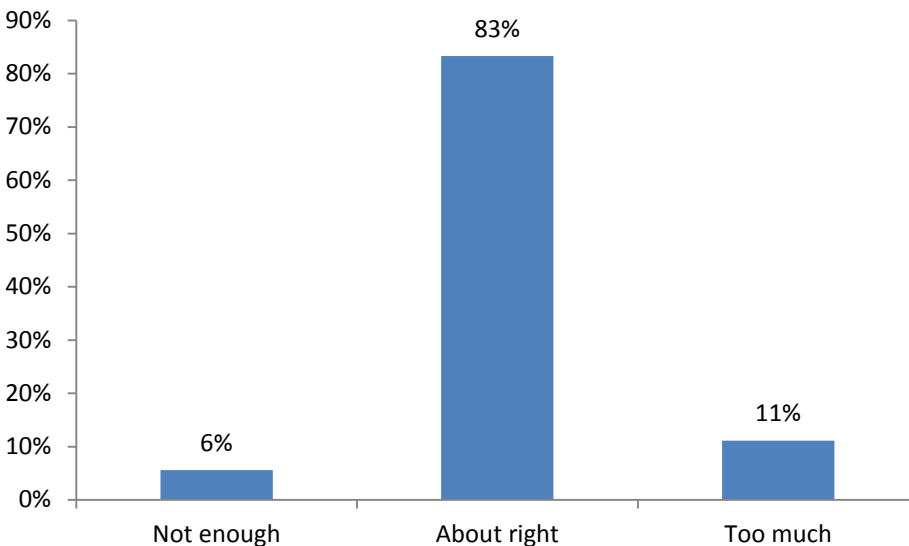
Figure 27. Training Length. June 20, 2012: Dr. Michael Reece.



June 21, 2012: The Waponahki Tribal Health Assessment: A multi-tribal collaboration between members of the Waponahki Confederacy and the University of Nebraska Medical Center, College of Public Health, featuring Patricia Knox-Nicola.

83% of respondents believed the length of the training was about right. 6% believed the training was too short and another 11% believed it was too long (n=18).

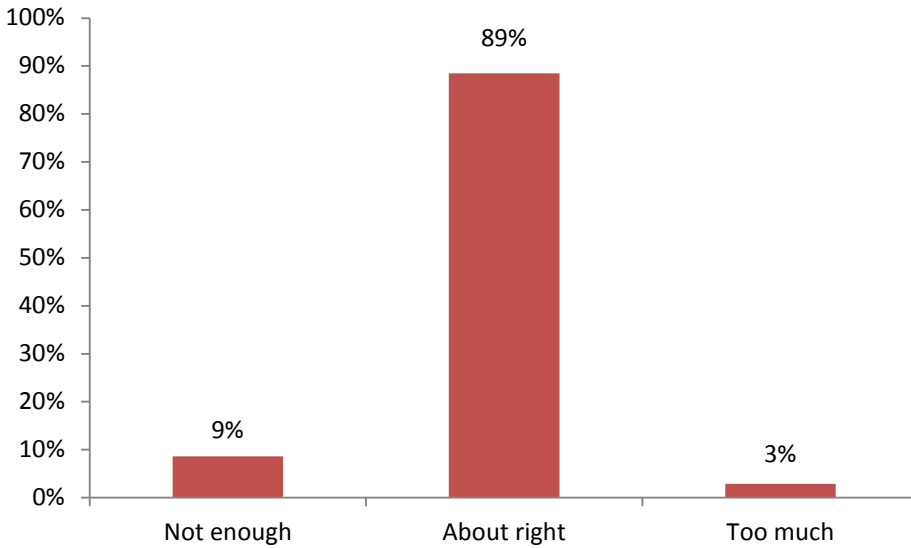
Figure 28. Training Length. June 21, 2012: Patricia Knox-Nicola.



All Events March 8, 2011 to June 30, 2012

89% of respondents believed the length of the trainings they attended were about right. 9% believed the trainings were too short and another 3% believed they were too long (n=139).

Figure 29. Training Length. All Events March 8, 2011 to June 30, 2012

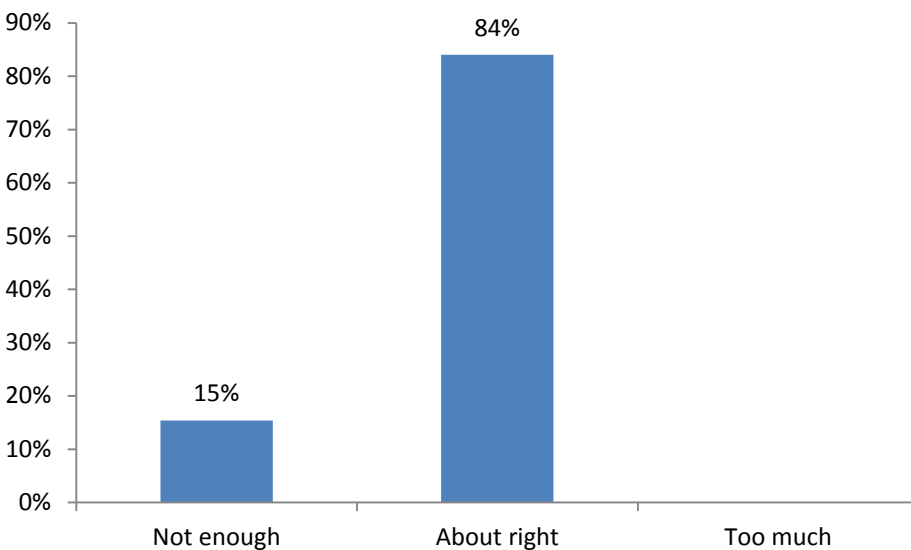


Continuing Education: Post-Event Perceptions of Amount of Training Information

March 8, 2012: The Challenges We Face, the Leaders We Need - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Fraser.

84% of respondents believed the amount of training information was about right. 15% believed the amount of training information was not enough (n=13).

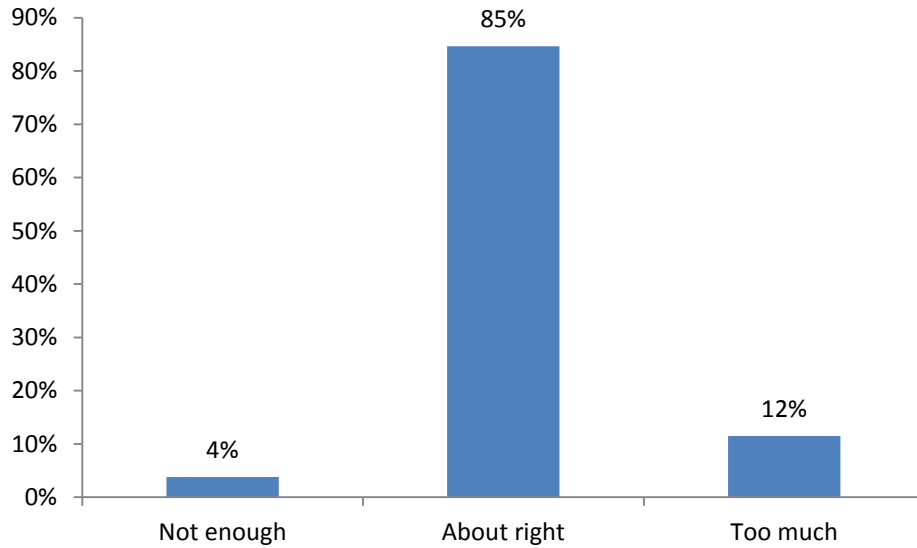
Figure 30. Training Information. March 8, 2012: Dr. Michael Fraser.



April 2, 2012: National Public Health Week: Community Kick-off Events

85% of respondents believed the amount of training information was about right. 4% believed the amount of training information was not enough, and 12% believed there was too much (n=26).

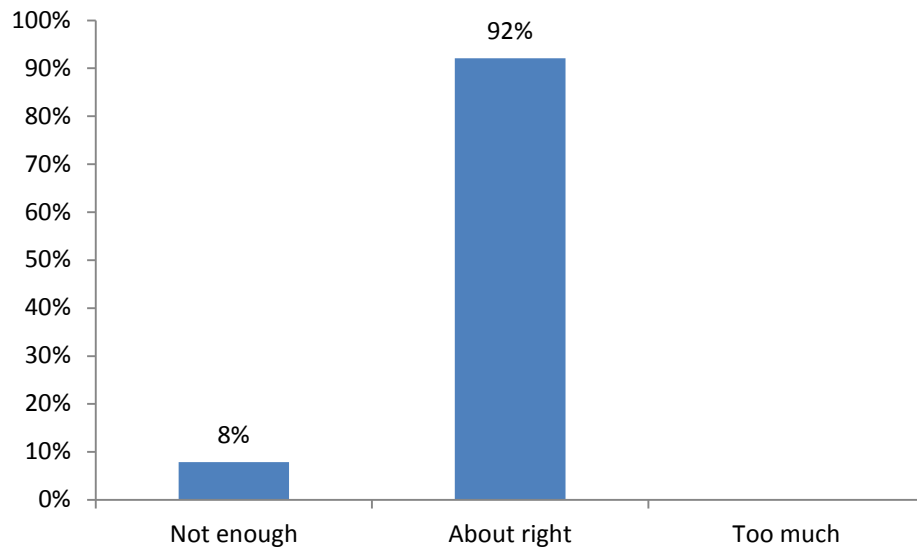
Figure 31. Training Information. April 2, 2012: National Public Health Week



April 6, 2012: Behavioral Health: Why It Matters to Public Health and What to Do About It - University of Nebraska Medical Center Leadership Speaker Series, featuring Laura Howard.

87% of respondents believed the length of the training was about right. 13% believed the training was too short (n=38).

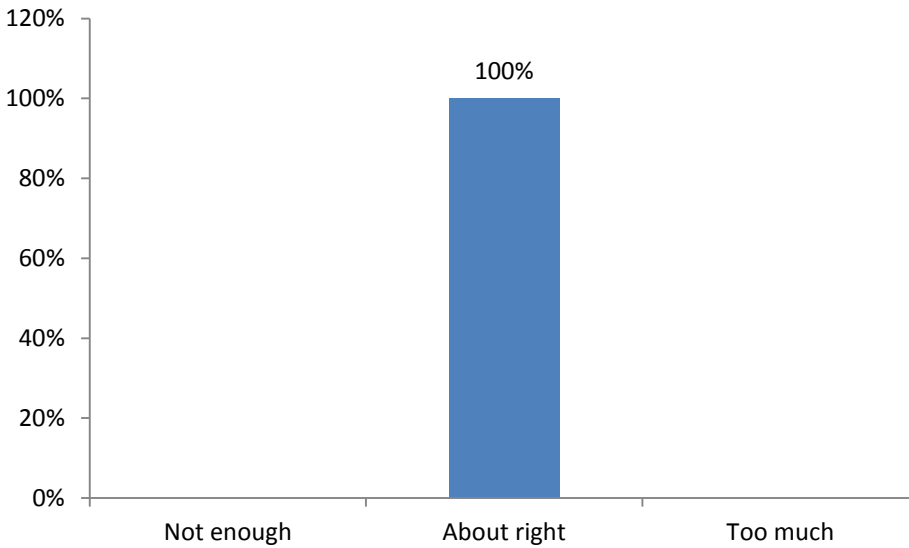
Figure 32. Training Information. April 6, 2012: Laura Howard.



June 19, 2012: 7th Annual Tribal Leader/Scholar Program at the National Congress of American Indians' Mid-Year Conference.

100% of respondents believed the amount of training information was about right (n=2).

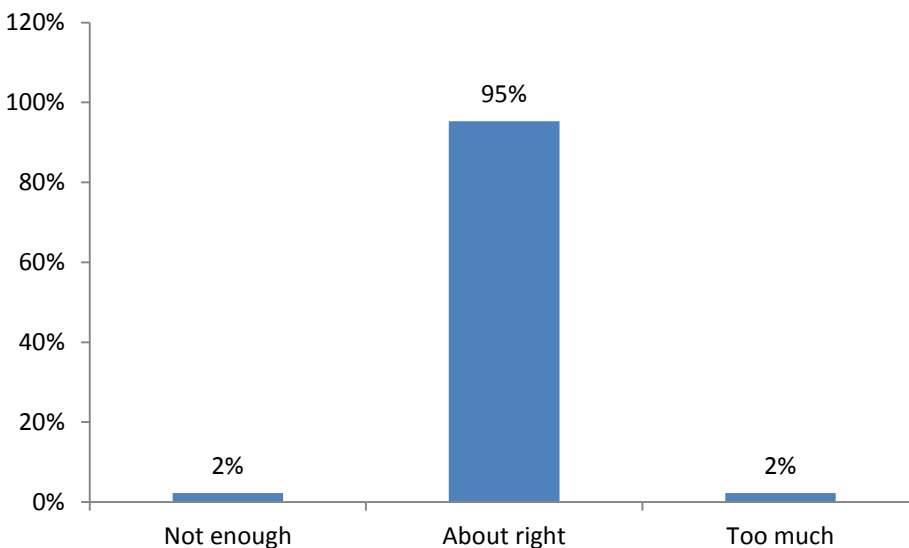
Figure 33. Training Information. June 19, 2012: 7th Annual Tribal Leader/Scholar Program



June 20, 2012: Nebraska Sexual Health Research in the 21st Century: Innovations and Future Directions - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Reece.

95% of respondents believed the amount of training information was about right. 2% believed the amount of training information was not enough, and 2% believed there was too much (n=43).

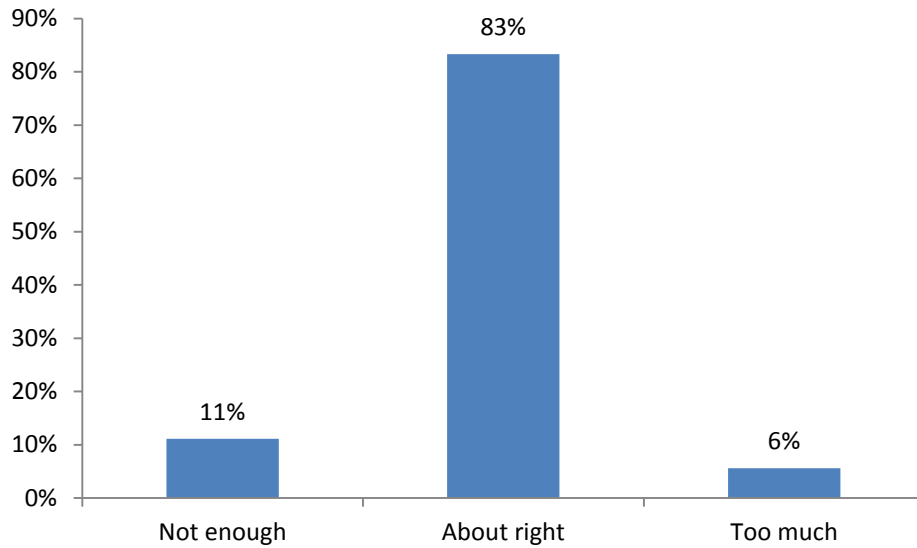
Figure 34. Training Information. June 20, 2012: Dr. Michael Reece.



June 21, 2012: The Waponahki Tribal Health Assessment: A multi-tribal collaboration between members of the Waponahki Confederacy and the University of Nebraska Medical Center, College of Public Health, featuring Patricia Knox-Nicola.

83% of respondents believed the amount of training information was about right. 11% believed the amount of training information was not enough, and 6% believed there was too much (n=18).

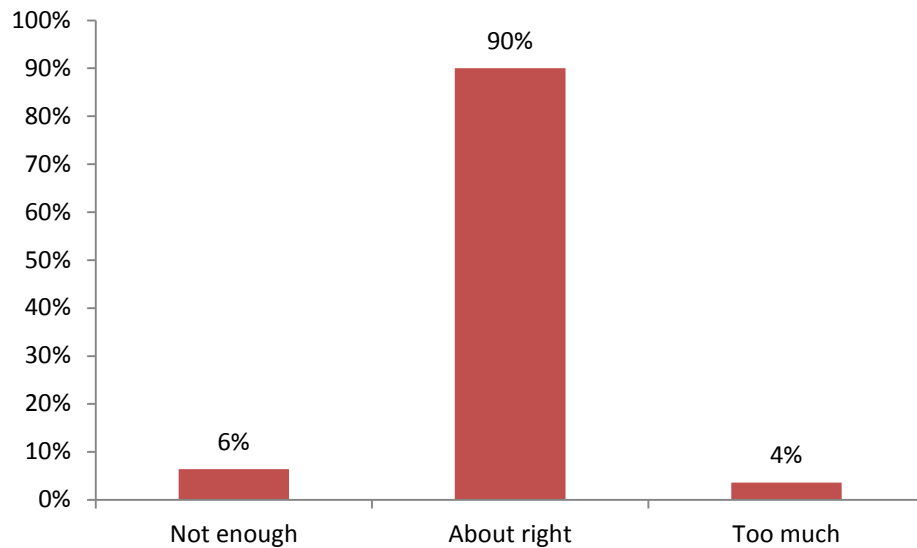
Figure 35. Training Information. June 21, 2012: Patricia Knox-Nicola.



All Events March 8, 2011 to June 30, 2012

90% of respondents believed the amount of information presented during trainings was about right. 11% believed the amount of training information was not enough, and 6% believed there was too much (n=140).

Figure 36. Training Information. All Events March 8, 2011 to June 30, 2012

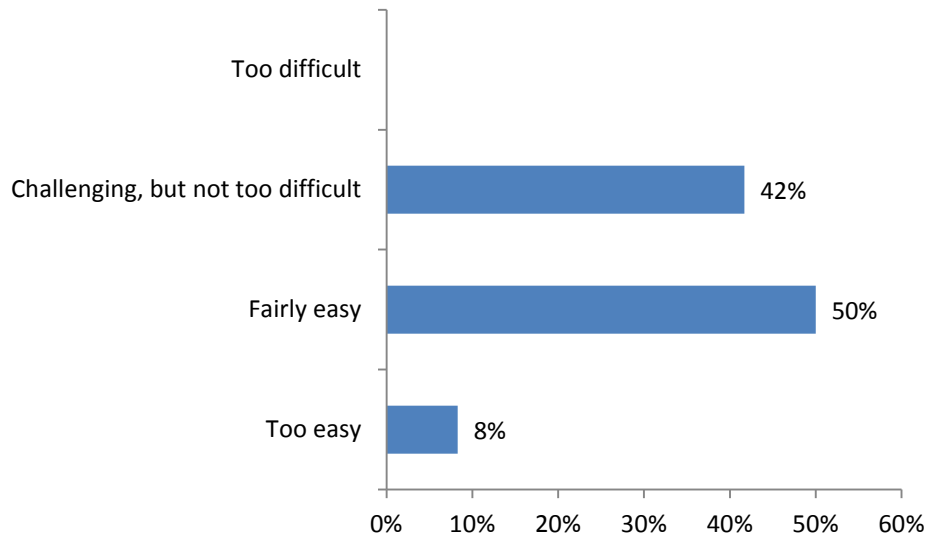


Continuing Education: Post-Event Perceptions of Training Difficulty

March 8, 2012: The Challenges We Face, the Leaders We Need - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Fraser.

42% of respondents believed the training was challenging, 50% believed it was fairly easy, and 8% believed it was too easy (n=12).

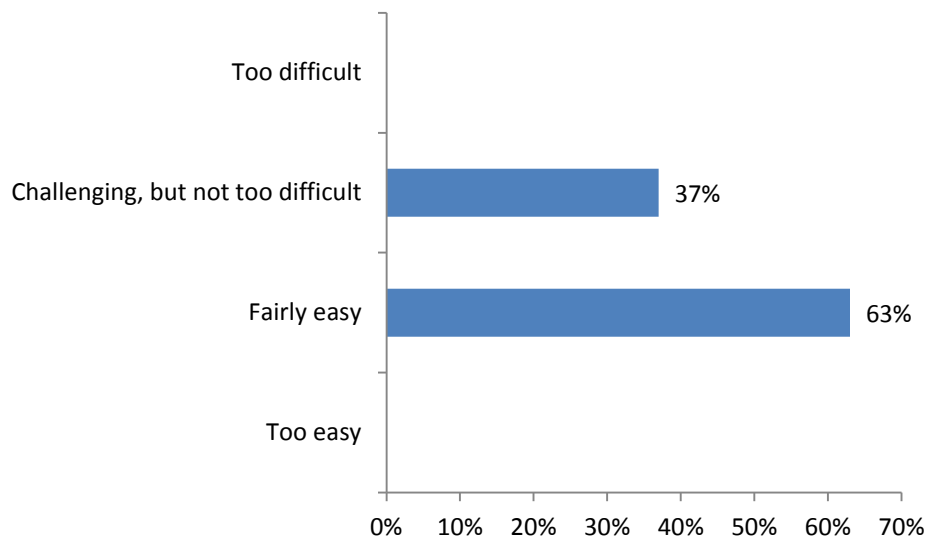
Figure 37. Training Difficulty. March 8, 2012: Dr. Michael Fraser.



April 2, 2012: National Public Health Week: Community Kick-off Events

37% of respondents believed the training was challenging, and 63% believed it was fairly easy (n=27).

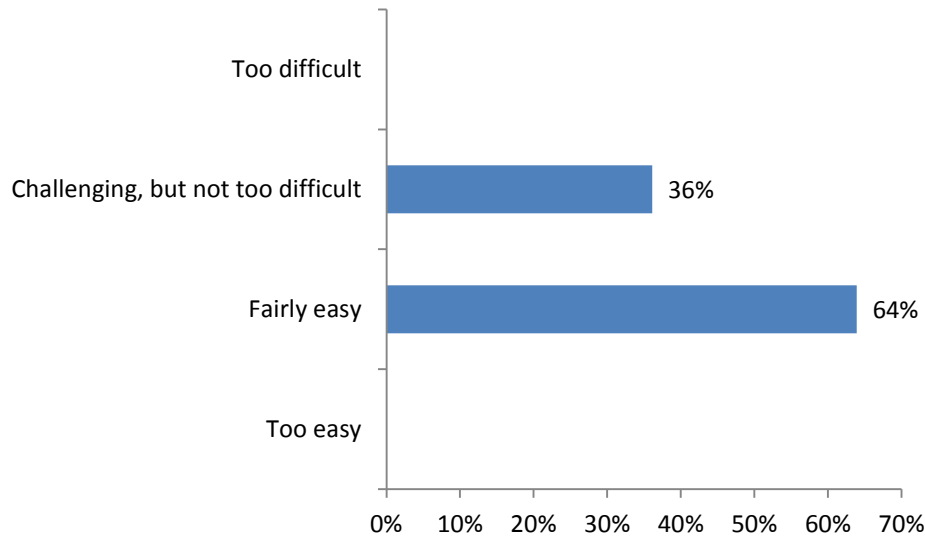
Figure 38. Training Difficulty. April 2, 2012: National Public Health Week



April 6, 2012: Behavioral Health: Why It Matters to Public Health and What to Do About It - University of Nebraska Medical Center Leadership Speaker Series, featuring Laura Howard.

36% of respondents believed the training was challenging, and 64% believed it was fairly easy (n=36).

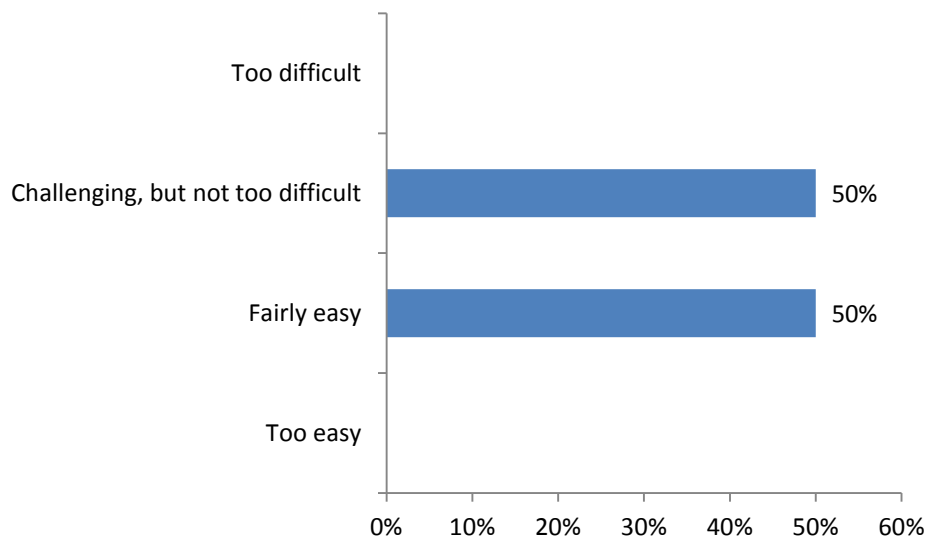
Figure 39. Training Difficulty. April 6, 2012: Laura Howard.



June 19, 2012: 7th Annual Tribal Leader/Scholar Program at the National Congress of American Indians' Mid-Year Conference.

50% of respondents believed the training was challenging, and 50% believed it was fairly easy. (n=2).

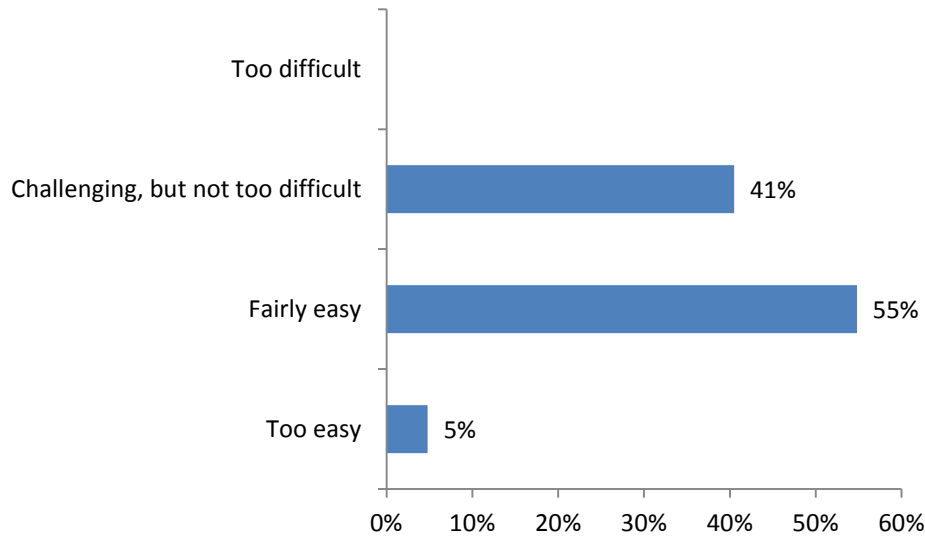
Figure 40. Training Difficulty. June 19, 2012: 7th Annual Tribal Leader/Scholar Program



June 20, 2012: Nebraska Sexual Health Research in the 21st Century: Innovations and Future Directions - University of Nebraska Medical Center Leadership Speaker Series, featuring Dr. Michael Reece.

41% of respondents believed the training was challenging, 55% believed it was fairly easy, and 5% believed it was too easy (n=42).

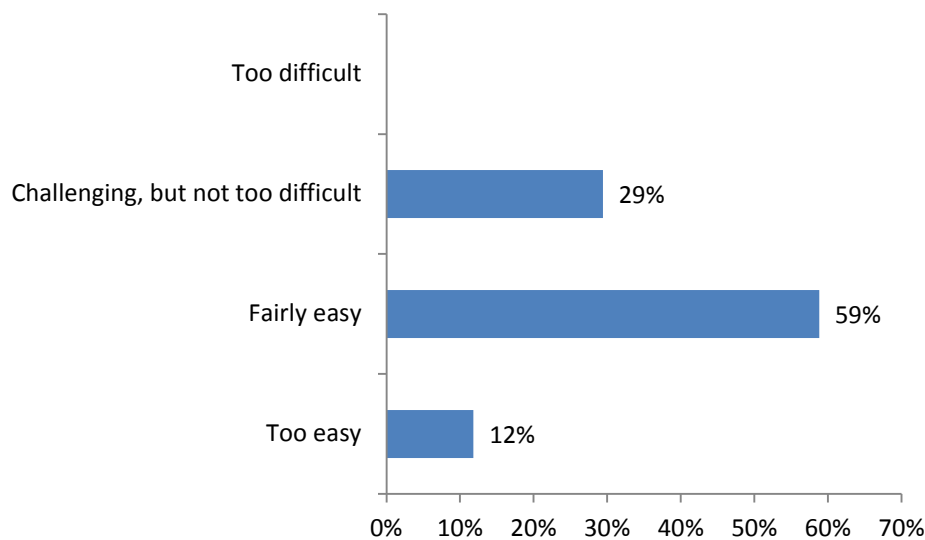
Figure 41. Training Difficulty. June 20, 2012: Dr. Michael Reece.



June 21, 2012: The Waponahki Tribal Health Assessment: A multi-tribal collaboration between members of the Waponahki Confederacy and the University of Nebraska Medical Center, College of Public Health, featuring Patricia Knox-Nicola.

29% of respondents believed the training was challenging, 59% believed it was fairly easy, and 12% believed it was too easy (n=17).

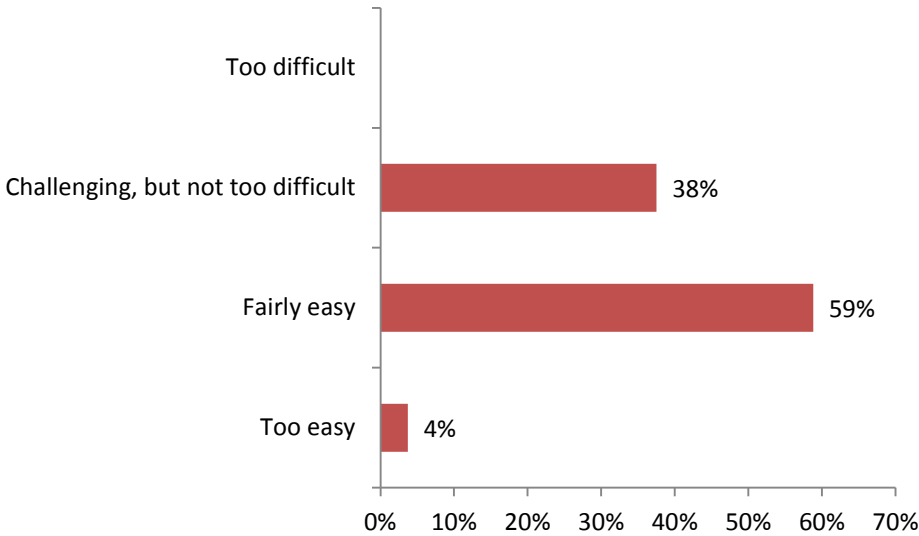
Figure 42. Training Difficulty. June 21, 2012: Patricia Knox-Nicola.



All Events March 8, 2011 to June 30, 2012

38% of respondents believed the training they participated in was challenging, 59% believed it fairly easy, and 4% believed it was too easy (n=136).

Figure 43. Training Difficulty. All Events March 8, 2011 to June 30, 2012



Preferred Learning Format

Unique Continuing Education Activity Participants were asked what their preferences for training activity setting and format were using a scale of 1 to 7, with 1="Not preferred at all" and 7="Very preferred". The training setting and format selections, and corresponding mean rating scores included:

In-person training session (one day or less with instructor): 3.96 (n=133)

In-person training session (multi-day workshop with instructor): 3.13 (n=132)

Live training via distance learning (connecting to a live training session with an instructor via distance learning technologies or a webinar): 3 (n=132)

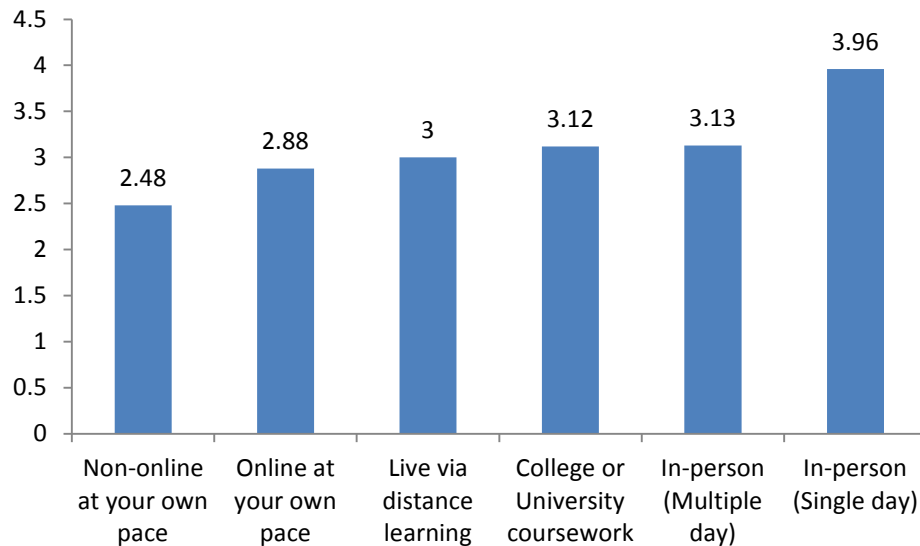
Online training at your own pace (completing training online at a self-directed pace): 2.88 (n=131)

Non-online training at your own pace (completing course work with paper and pencil assignments and readings at a self-directed pace): 2.48 (n=130)

College or university course work with or without credit (regularly attending a class for an academic term): 3.12 (n=133)

The most preferred setting and format was thus in-person training in a single day, and the least preferred was non-online training conducted at your own pace (see Figure 44).

Figure 44. Preferred Learning Format



Preferred Characteristics of Training

Unique Continuing Education Activity Participants were asked how important particular training activity characteristics were to them using a scale of 1 to 5, with 1="Low importance" and 5="High importance". Training characteristics and corresponding mean rating scores included:

Opportunity to interact face-to-face with an instructor: 4.11 (n=132)

Opportunity to interact face-to-face with other participants: 4.09 (n=132)

Being part of a group that is at the same learning level: 3.58 (n=132)

Being part of a group with students at different levels of experience: 3.45 (n=132)

Availability of continuing education credits: 2.98 (n=131)

Availability of financial aid (travel stipends, scholarships, support for course books, etc.): 3.45 (n=130)

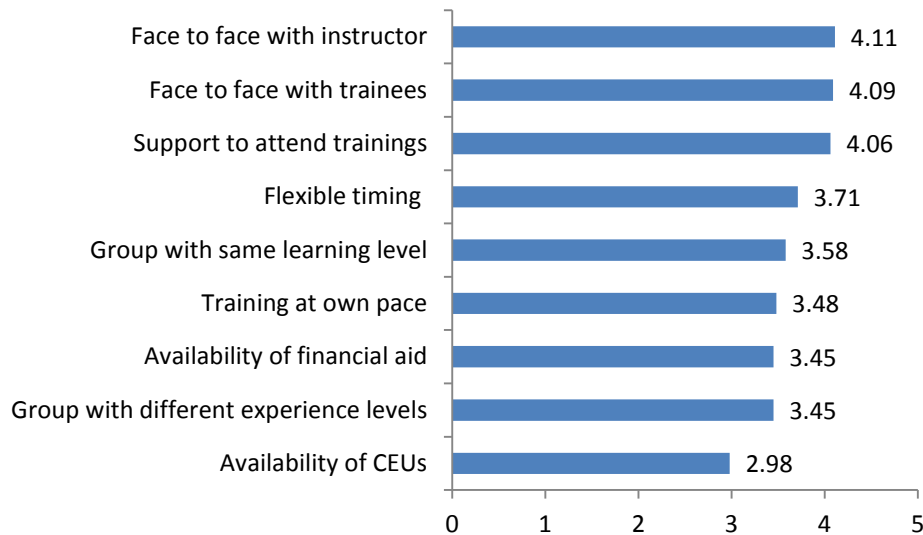
Support from employers/superiors to attend trainings: 4.06 (n=130)

Flexible timing (learning in the evenings or weekends): 3.71 (n=129)

Opportunity to complete training at your own pace: 3.48 (n=129)

The most important characteristic of training was the opportunity to interact face-to-face with an instructor, and the least important was the availability of continuing education credits (see Figure 45).

Figure 45. Preferred Characteristics of Training



Public Health Leadership Institute

Established in 2005, the Great Plains Public Health Leadership Institute (PHLI) is a year-long competency-based training program designed for established and emerging leaders in organizations in our region whose primary mission is to improve the health and well-being of populations and communities. A robust experiential curriculum includes residential and distance learning, mentoring and coaching, and collaborative practice projects.

A separate evaluation was conducted for the Public Health Leadership Institute for the 2011-12 year. A total of 22 individuals enrolled in the Leadership Institute. Limited demographic and professional information is presented below (see Figure 46).

Figure 46. Leadership Institute Trainees

Total Entering Class, 2011	22
Gender	
Female	17 (77%)
Male	5 (9%)
Race	
American Indian or Alaskan Native	3 (14%)
Asian or Pacific Islander	1 (5%)
Black or African-American	3 (14%)
White	13 (60%)
Unknown	2 (9%)
Current Employment Background	
Employed in Rural Areas	5 (9%)
Employed in Medically Underserved Areas	15 (68%)

A pre-event survey of public health leadership competencies was conducted of the Leadership Institute participants at the beginning of the Institute. Results from pre-Institute self-assessments of leadership competencies are presented in figures 47-70.

Figure 47. Feedback, Coaching, Mentoring

Understand and practice the skills of feedback, coaching, and mentoring.

How important is this competency for public health practice?	4.04
How relevant is this competency to your leadership role(s)/responsibilities?	4.17
How strong is your current mastery of this competency?	2.92
How high of a training priority is this competency to your leadership development?	3.88

Figure 48. Conflict Management

Understand and practice effective skills of conflict management.

How important is this competency for public health practice?	4.46
How relevant is this competency to your leadership role(s)/responsibilities?	4.42
How strong is your current mastery of this competency?	2.96
How high of a training priority is this competency to your leadership development?	4.17

Figure 49. Negotiation Skills

Understand and practice negotiation skills.

How important is this competency for public health practice?	4.38
How relevant is this competency to your leadership role(s)/responsibilities?	4.13
How strong is your current mastery of this competency?	3.04
How high of a training priority is this competency to your leadership development?	3.75

Figure 50. Personal Styles

Understand own personal styles, behaviors, preferences, and mission for leadership.

How important is this competency for public health practice?	4.50
How relevant is this competency to your leadership role(s)/responsibilities?	4.38
How strong is your current mastery of this competency?	3.25
How high of a training priority is this competency to your leadership development?	4.00

Figure 51. Data for Decision-Making

Know how to use data for decision-making.

How important is this competency for public health practice?	4.71
How relevant is this competency to your leadership role(s)/responsibilities?	4.50
How strong is your current mastery of this competency?	3.71
How high of a training priority is this competency to your leadership development?	3.75

Figure 52. Ethical Practice

Understand and model ethical practice in your organization and community.

How important is this competency for public health practice?	4.63
How relevant is this competency to your leadership role(s)/responsibilities?	4.50
How strong is your current mastery of this competency?	3.92
How high of a training priority is this competency to your leadership development?	3.38

Figure 53. Cultural Competence

Understand and model cultural competence in your organization and community.

How important is this competency for public health practice?	4.58
How relevant is this competency to your leadership role(s)/responsibilities?	4.42
How strong is your current mastery of this competency?	3.38
How high of a training priority is this competency to your leadership development?	3.83

Figure 54. Power and Influence

Understand and manage power and influence.

How important is this competency for public health practice?	4.46
How relevant is this competency to your leadership role(s)/responsibilities?	4.37
How strong is your current mastery of this competency?	2.96
How high of a training priority is this competency to your leadership development?	4.29

Figure 55. Organizational Change

Understand and lead organizational change.

How important is this competency for public health practice?	4.71
How relevant is this competency to your leadership role(s)/responsibilities?	4.46
How strong is your current mastery of this competency?	2.87
How high of a training priority is this competency to your leadership development?	4.67

Figure 56. Evaluation and Accountability

Understand and promote evaluation and accountability.

How important is this competency for public health practice?	4.67
How relevant is this competency to your leadership role(s)/responsibilities?	4.63
How strong is your current mastery of this competency?	3.63
How high of a training priority is this competency to your leadership development?	4.04

Figure 57. Understanding Trends

Assure organizational knowledge and understanding of public health trends, issues, and forecasting.

How important is this competency for public health practice?	4.67
How relevant is this competency to your leadership role(s)/responsibilities?	4.29
How strong is your current mastery of this competency?	3.25
How high of a training priority is this competency to your leadership development?	4.04

Figure 58. Build Teams

Know how to build and sustain teams.

How important is this competency for public health practice?	4.58
How relevant is this competency to your leadership role(s)/responsibilities?	4.29
How strong is your current mastery of this competency?	3.04
How high of a training priority is this competency to your leadership development?	4.25

Figure 59. Disparities and Inequities

Understand and address health disparities and inequities.

How important is this competency for public health practice?	4.58
How relevant is this competency to your leadership role(s)/responsibilities?	4.17
How strong is your current mastery of this competency?	3.50
How high of a training priority is this competency to your leadership development?	3.75

Figure 60. Collaborative Leadership

Understand and practice collaborative leadership.

How important is this competency for public health practice?	4.58
How relevant is this competency to your leadership role(s)/responsibilities?	4.37
How strong is your current mastery of this competency?	3.21
How high of a training priority is this competency to your leadership development?	4.12

Figure 61. Crisis Leadership

Understand and practice crisis leadership.

How important is this competency for public health practice?	4.17
How relevant is this competency to your leadership role(s)/responsibilities?	3.75
How strong is your current mastery of this competency?	2.88
How high of a training priority is this competency to your leadership development?	3.83

Figure 62. Networks and Coalitions

Know how to develop and sustain effective networks and coalitions.

How important is this competency for public health practice?	4.63
How relevant is this competency to your leadership role(s)/responsibilities?	4.25
How strong is your current mastery of this competency?	3.08
How high of a training priority is this competency to your leadership development?	4.04

Figure 63. Communication

Understand and practice a range of communication skills including risk, crisis communication, electronic and storytelling.

How important is this competency for public health practice?	4.21
How relevant is this competency to your leadership role(s)/responsibilities?	4.04
How strong is your current mastery of this competency?	3.21
How high of a training priority is this competency to your leadership development?	3.79

Figure 64. Social Marketing

Understand and practice social marketing skills.

How important is this competency for public health practice?	4.21
How relevant is this competency to your leadership role(s)/responsibilities?	3.58
How strong is your current mastery of this competency?	2.79
How high of a training priority is this competency to your leadership development?	3.37

Figure 65. Political Advocacy

Understand and practice political advocacy for change.

How important is this competency for public health practice?	4.50
How relevant is this competency to your leadership role(s)/responsibilities?	3.83
How strong is your current mastery of this competency?	2.71
How high of a training priority is this competency to your leadership development?	3.83

Figure 66. Media Skills

Understand and practice skills of media communication.

How important is this competency for public health practice?	4.21
How relevant is this competency to your leadership role(s)/responsibilities?	3.75
How strong is your current mastery of this competency?	3.00
How high of a training priority is this competency to your leadership development?	3.67

Figure 67. Political Landscapes

Understand political landscapes, processes, and systems.

How important is this competency for public health practice?	4.58
How relevant is this competency to your leadership role(s)/responsibilities?	4.08
How strong is your current mastery of this competency?	2.83
How high of a training priority is this competency to your leadership development?	3.92

Figure 68. Public Health Resources

Know how to make the case for public health resources.

How important is this competency for public health practice?	4.75
How relevant is this competency to your leadership role(s)/responsibilities?	4.25
How strong is your current mastery of this competency?	2.92
How high of a training priority is this competency to your leadership development?	4.17

Figure 69. Crises Investigation

Guide and mediate the investigation and resolution of acute public health crises.

How important is this competency for public health practice?	4.38
How relevant is this competency to your leadership role(s)/responsibilities?	3.58
How strong is your current mastery of this competency?	2.50
How high of a training priority is this competency to your leadership development?	3.67

Figure 70. Systems Thinking

Understand and promote systems thinking.

How important is this competency for public health practice?	4.50
How relevant is this competency to your leadership role(s)/responsibilities?	4.25
How strong is your current mastery of this competency?	3.21
How high of a training priority is this competency to your leadership development?	3.87

CONCLUSION

Within the inaugural year of the Great Plains Public Health Training Center, the Center engaged 233 members of the public health workforce in continuing education and experiential training opportunities. This included convening eleven continuing education events, a field placement program which placed interns at ten local health departments of public health organizations across the state, and initiating a collaborative projects program. Evaluation results indicate that continuing education participants were highly satisfied with the quality and content of continuing education events they participated in.

A framework for long-term evaluation of impact on competencies among trainees has been established. This evaluation data is currently being collected and will provide insight into impact of training activities on participants. Follow-up competency data will be collected from first year experiential trainees, and continuing education trainees at a period of one-year following their initial entrance into the Training Center.