

# Evaluation Report of the Great Plains Public Health Training Center For the Reporting Period of July 1, 2012 to June 30, 2013

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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 (GPPHTC or 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 (UNMC), College of Public Health (COPH). Highlights of activities and findings from the Training Center's second year (FY 2012-2013) include the following:

- The Training Center sponsored or co-sponsored fourteen continuing education training events, offered seven online training modules, and supported eight field placement externships and four student-faculty collaborative projects in rural and urban communities across Nebraska.
- A total of 332 individuals participated in Training Center activities in year 2. This was a 42% increase in the number of individuals who participated in training activities from year 1 to year 2.
- Training Center participants were more diverse in year 2 than year 1. In year 2, approximately 78% of activity participants were female (compared to 72% in year 1), and 21% were racial minorities (compared to 17% in year 1).
- Ninety percent (90%) of in-person, continuing education activity participants believed their knowledge of the subject matter increased as a result of those training activities. Ninety-two percent (92%) of online module training participants believed their knowledge of the subject matter increased following those online trainings.
- When asked to self-assess their public health competencies, Training Center participants felt they were most competent in cultural competency skills (average of 3.53 out of 5). However, their lowest self-assessed competency domain was in tribal health skills (average of 2.29 out of 5).
- One year after participating in Training Center activities that were initiated in 2012, participants believed that the Training Center impacted them positively on both individual and organizational levels, as well as in their abilities to serve underserved populations, as well as provide public health services in general. Self-assessed public health core competencies increased among training participants in nine out of ten domains after one year. However, those increases may have been due to chance.

## OVERVIEW OF ACTIVITIES

### Experiential Activities

The Training Center convened two separate forms of experiential activities within the reporting year. First, it convened a series of field placement experiences across the state. The field placements were 200 hour externships at local public health departments. Eight trainees participated in field placements – two in the urban areas of Lincoln and Omaha, and the remaining six in rural communities. Each field placement student worked under a designated preceptor at a local public health department, and a program manager based at the Training Center provided off-site guidance throughout the experience. Work roles and responsibilities varied across field placements. Trainees were exposed to a variety of practice, administrative, and analytical environments and tasks in real world settings.

Examples of field placement activities that trainees participated in included:

- Reviewing and administering training on the use of health literacy software among local health department staff.
- Supporting local preparedness activities, including disease surveillance and active shooter scenarios.
- Production of GIS maps containing data on nutritional needs, radon testing, and fetal infant mortality.
- Developing social marketing strategies targeting food safety, health interventions, and education within the local retail food preparation industry.
- Developing pedestrian and bike safety curriculums for local summer school programs.

Although experiences and settings varied, all field placements were competency based, and trainees participated in online and in-person activities together to facilitate shared understandings of practice experiences. All eight trainees successfully completed their respective field placement requirements.

The Training Center also convened four, 300-hour faculty student collaborative projects. The purpose of the collaborative projects were to both support faculty research in applied public health areas, and provide learning opportunities for student research assistants to work with the faculty in these projects. The four collaborative projects included the following:

- *Indoor Air Quality in Residences and Schools on the Winnebago Reservation*

This project explored the Indoor Air Quality in Residences and Schools on the Winnebago Reservation. In this project, a UNMC College of Public Health faculty member and College of Public Health Graduate Student partnered with the Winnebago Health Department to 1) characterize indoor air quality - measuring carbon dioxide, carbon monoxide, radon, and particulate matter in homes and schools on the Winnebago reservation; and 2) provide hands-on research training to senior college students as a way to increase research capacity on the reservation. The long-term goal of the project is to establish a mutually respectful, sustainable, working relationship between the Winnebago Tribe and the University of Nebraska Medical Center, College of Public Health, to improve health among residents of the Winnebago reservation.

- Nebraska Adult Sexual Literacy

In this project, the Midlands Sexual Health Research Collaborative and the Nebraska Sexual Health Coalition partnered with the UNMC College of Public Health and the Douglas County Health Department. The purpose of the project was to research the sexual literacy of a generalizable, population-based sample of Nebraska adults to inform interventions aimed at increasing sexual literacy. Primary activities for the study were conducted in Omaha with collaborative partners from across the state, including in Lincoln (urban), Kearney (rural), Hastings (rural), Wisner (rural), and Scottsbluff (rural). Over the long term, the project aims to build sustainable community-academic partnerships to address sexual health in Nebraska through a collaborative research process.

- Do JuSTice

The Do JuSTice project involved a UNMC College of Public Health faculty member, a PhD student in the COPH and the Douglas County Department of Corrections. Individuals involved worked to reduce the local epidemic rates of sexually transmitted infections in Douglas County by targeting high risk individuals in the correctional system, incorporating interactive educational program to inform inmates about STIs, and offering rapid HIV screening and counseling.

- Short Course in Health Policy

The Short Course in Health Policy project involved a UNMC College of Public Health faculty member, a College of Public Health MPH student, and the Nebraska Department of Health and Human Services (Office of Community Health and Performance Management). In this project, the UNMC College of Public Health partnered with the Nebraska Department of Health and Human Services to offer a short course in health policy for public health professionals across the state. This workshop provided a foundation for mounting successful policy-making efforts. It also prepared teams interested in securing additional experiential training to enter the Health Policy Academy, a current effort within the College of Public Health that aims to engage teams of state, local, and tribal health leaders in strengthening policy development and advocacy to benefit their communities' health.

All four GPPHTC collaborative projects were either completed or on schedule for completion.

## Continuing Education Training Activities

The Great Plains Public Health Training Center also continued to provide continuing education activities throughout the reporting year. These included both in-person activities, as well as online only modules accessible through a Learning Management System. Many of the in-person activities were also accessible via webinar, and recorded and made accessible via the GPPHTC Learning Management System for individuals who wanted to view the training seminars on their own.

The Center convened or co-sponsored a total of fourteen in-person training events and produced seven online training modules during the July 1, 2012 to June 30, 2013 reporting period. Those events included:

**Event 1: August 6, 2012 – Student Fellowship On-site Training**

University of Nebraska Medical Center  
Maurer Center for Public Health

984355 Nebraska Medical Center  
Omaha, NE 68198-4355

This was a seminar for graduating trainees from the first year field placement program to reflect and share their field placement experiences with each other, and faculty and students at the UNMC College of Public Health. Students discussed what they learned during their field placements, reviewed outcomes from their field placement projects, and discussed future educational and career plans in public health or health sciences.

**Event 2: August 9, 2012 - East Central District Health Department & Good Neighbor Community Health Center Workshop: Five Dysfunctions of a Team**

Highland Park Evangelical Free Church  
4115 38<sup>th</sup> St.  
Columbus, NE 68601

This was a presentation and discussion directed towards local health department staff based on the 'Five Dysfunctions of a Team' model. Discussion included challenges and opportunities of leadership and team building, critical thinking, conflict styles, and human resource management issues within the context of public health workforce management.

**Event 3: August 13-16, 2012 – Train the Trainer Evidence-Based Public Health Course**

Kaplan University  
1821 K St.  
Lincoln, NE 68508

This was a three and a half day course targeting state and local health department staff, and UNMC College of Public Health students and faculty, in evidence based public health practices. The intention of the course was to prepare a training cadre that will further disseminate training on evidence-based public health strategies throughout Nebraska.

**Event 4: September 11, 2012 – Implementing the Affordable Care Act: The Current State of Play: Implications of the affordable care act as it relates to Health Care and Public Health**

University of Nebraska Medical Center  
Maurer Center for Public Health  
984355 Nebraska Medical Center  
Omaha, NE 68198-4355

Professor Sarah Rosenbaum (George Washington University School of Public Health and Health Services) presented an analysis of the impact of the Supreme Court's decision in *NFIB v Sebelius* on implementation of the Affordable Care Act (ACA), and implications of the ACA's implementation in the current federal budget environment.

**Event 5: September 26, 2012 – Priority Areas for Improvement of Quality in Public Health**

Holiday Inn  
2503 South Locust St.  
Grand Island, NE 68801

Dr. Peggy Honoré (Director of Public Health System, Finance, and Quality Program - Office of Healthcare Quality of the Assistant Secretary for Health) provided an overview of strategies and areas for improvement of public health systems, including in finance and minority health disparities. She discussed concepts of quality in the public health system, and the promotion of public health systems research in quality and outcomes.

**Event 6: September 26, 2012 – National Prevention Strategy Summit**

University of Nebraska Medical Center  
Maurer Center for Public Health  
984355 Nebraska Medical Center  
Omaha, NE 68198-4355

Dr. Jeff Levi (CEO of Trust for America and a member of the Advisory Group on Prevention, Health Promotion, and Integrative Public Health) provided a keynote overview of the National Prevention Strategy. Public health researchers and advocates discussed prevention efforts and challenges in the local context, such as obesity and healthy eating and living, access to care, and payment issues.

**Event 7: September 27, 2012 - National Prevention Strategy Summit**

Holiday Inn  
2503 South Locust St.  
Grand Island, NE 68801

Dr. Jeff Levi (CEO of Trust for America and a member of the Advisory Group on Prevention, Health Promotion, and Integrative Public Health) provided a keynote overview of the National Prevention Strategy. Public health researchers and advocates discussed prevention efforts and challenges in the local context, particularly those facing rural communities in Nebraska.

**Event 8: November 1, 2012 – Health Disparities and Healthy Equity**

University of Nebraska Medical Center  
Maurer Center for Public Health  
984355 Nebraska Medical Center  
Omaha, NE 68198-4355

This event focused on health disparities and equity issues within Nebraska, particularly within tribal communities. The event was conducted in partnership with the local Urban Indian Health Center and Tribal 638 Compact Health Center program.

**Event 9: January 8, 2013 - Moving from Cultural Competence to Cultural Humility: Leadership Needs and Challenges**

Dr. Melanie Tervalon discussed the need for public health leaders to embrace and practice cultural humility in environments with diverse workforces and clients, and recognize the distinction between being culturally competent and the new paradigm of cultural humility.

**Event 10: January 9, 2013 - Cultural Humility versus Cultural Competence: A Critical Distinction**

University of Nebraska Medical Center  
Maurer Center for Public Health  
984355 Nebraska Medical Center



Omaha, NE 68198-4355

Dr. Melanie Tervalon discussed the need for public health practitioners and the health sector to become more responsive to the needs of diverse communities, modeling respect for divergent points of view, and prioritizing inclusive policies and practices in all settings.

**Event 11: April 2, 2013 – COPH Grand Rounds: Nebraska Early Hearing Detection and Intervention Program**

University of Nebraska Medical Center  
Maurer Center for Public Health  
984355 Nebraska Medical Center  
Omaha, NE 68198-4355

Jim Beavers, Kathy Northrop, and Melissa Butler (Nebraska Early Hearing Detection and Intervention (NE-EHDI) Program, Nebraska Department of Health and Human Services) discussed the program and its goals, and presented an overview of key statistics. The event was convened as part of National Public Health Week.

**Event 12: April 3, 2013 – Preparing for the Zombie Apocalypse or Other Events Slightly More Likely**

University of Nebraska Medical Center  
Maurer Center for Public Health  
984355 Nebraska Medical Center  
Omaha, NE 68198-4355

Dr. Shawn Gibbs (Department of Environmental, Agricultural, and Occupational Health at the University of Nebraska Medical Center) provided an overview on the importance of disaster preparedness and planning. The event was convened as part of National Public Health Week.

**Event 13: April 12, 2013 – Achieving Healthy Equity: Addressing the Impacts of Racism on Health**

University of Nebraska Medical Center  
Maurer Center for Public Health  
984355 Nebraska Medical Center  
Omaha, NE 68198-4355

Dr. Camara Phyllis Jones, from the Rollins School of Public Health (Emory), discussed the interplay of race, racism, and health outcomes. She discussed the social determinants of health and equity, three levels of racism in society, and racial category distinctions in data from the Behavioral Risk Factor Surveillance System.

**Event 14: April 22, 2013 – Public Health Policy Short Course**

Kearney Public Library  
2020 First Avenue  
Kearney, NE 68847

Carolyn Crump and James Emery (University of North Carolina School of Public Health) facilitated a one day workshop on public health policy. The workshop included an overview of the overall public health policy context and problem-solving, policy formulation and analysis, stakeholder power analysis, working with the media, and policy intervention evaluation.

The GPPHTC created and offered seven online modules on various topical areas. Each of the online trainings were offered for free, and amounted to 1 contact hour or .1 continuing education units. Those seven modules included:

- Public Health 101: Definition and History of Public Health
- Public Health 101: Core Functions, Essential Services, and Ethical Practices
- Public Health 101: Introduction to Health Promotion and Disease Prevention
- Public Health 101: Introduction to Epidemiology
- Public Health 101: Introduction to Biostatistics
- Public Health 101: 8 Healthy Home Principles
- Evaluation

## 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.

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. A **post-event survey** was also developed, which was designed to largely collect information on respondents' perceptions of their training experience. Additionally, a **one year impact survey** was also created and administered to gather information from individuals who had received training during year 1 of the Training Center.

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. That same contact information was used to contact trainees and administer the one year impact survey.

There are limitations that should be noted about the evaluation. Data was collected from most, but not all of the training activities. In the case of some of these training events, partners preferred not to use the evaluation surveys developed by the evaluation team, or a separate evaluation process was conducted. This included the August 6, 2012, Student Fellowship On-site Training; the August 13-16, 2012, Train the Trainer Evidence-Based Public Health Course; and the September 26 and 27<sup>th</sup>, 2012, National Prevention Strategy Summit forums.

It should also be noted that in the Year 1 evaluation, an effort was made to obtain more in-depth evaluation data from experiential trainees, including through the use of a separate post-experiential survey and interview process. In Year 2, due to severe funding cuts to the national public health training center program, it was unclear what programming changes would be made to the GPPHTC both within

that year and in subsequent years, and both training programming and evaluation activities were significantly curtailed. Thus, experiential evaluation data we had initially anticipated gathering near the end of the reporting year did not occur.

## RESULTS

### Who Participated in the Great Plains Public Health Training Center?

#### Definitions

Two principal types of individuals participated in GPPHTC activities during the Year 2 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 participants 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 health departments or became involved in collaborative public health projects during the reporting year. 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, 2012 to June 30, 2013 reporting period, there were a total of 332 total unique participants, including 320 **unique continuing education activity participants** and 12 **unique experiential activity participants** (see Figure 1).

**Figure 1. Unique Participants**

Unique continuing education activity participants	Unique experiential activity participants	Total unique participants
320	12	332

Compared to Year 1 of the GPPHTC (July 1, 2011 to June 30, 2012), the total number of unique individuals who participated in training activities in Year 2 increased 42% (see Figure 2).

**Figure 2. Year 1 and Year 2 Participation**

	Year 1 (2011-2012)	Year 2 (2012-2013)	Percent change
Unique continuing education activity participants	220	320	+45%
Unique experiential activity participants	13	12	-8%
Total unique participants	233	332	+42%

### Unique Participant Demographics

It should be noted that there were a significant amount of training participants in Year 2 events who did not complete survey information. The demographic information collected thus only reflects the data collected from survey respondents. Of the responding participants, 78% of unique training participants were female (see Figure 3). Approximately 4% were of Hispanic/Latino ethnicity (see Figure 4), and 21% of participants were non-white (see Figure 5). Compared to Year 1, this was a proportional increase of female unique training participants (72% in Year 1 to 78% in Year 2), and an increase in racial minority participants (17% in Year 1 to 21% in Year 2).

**Figure 3. Gender of Unique Participants**

Unique continuing education activity participants (n=248)		Unique experiential activity participants (n=10)		Total unique participants (n=258)	
Female	Male	Female	Male	Female	Male
197 (79%)	51 (21%)	6 (60%)	4 (40%)	203 (78%)	55 (21%)

**Figure 4. Ethnicity of Unique Participants**

Unique continuing education activity participants (n=245)		Unique experiential activity participants (n=9)		Total unique participants (n=254)	
Hispanic /Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino	Hispanic/Latino	Non-Hispanic/Latino
9 (4%)	236 (96%)	0 (0%)	9 (100%)	9 (4%)	245 (97%)

**Figure 5. Race of Unique Participants**

Race	Unique continuing education activity participants (n=244)	Unique experiential activity participants (n=10)	Total unique participants (n=254)
American Indian or Alaskan Native	3 (1%)	-	3 (1%)
Asian (Chinese, Filipino, Japanese, Korean, Asian Indian, or Thai origin)	16 (7%)	1 (10%)	17 (7%)
Asian (Any Asian origin other than Chinese,	10 (4%)	-	10 (4%)

Filipino, Japanese, Korean, Asian Indian, or Thai origin)			
Black or African-American	22 (9%)	-	22 (9%)
White	185 (76%)	9 (90%)	194 (76%)
Other	8 (3%)	-	8 (3%)

### Total Activity Participant Information

As previously noted, we were able to determine total counts of participants who attended continuing education activities. It is important to note that this includes individuals who attended multiple continuing education events. However, it serves as a reflection of the reach of the Training Center’s continuing education activities during the reporting period. There were a total of 429 continuing education activity participants (see Figure 6). Thus, when combined with the 12 unique experiential activity participants, the combined total of all Training Center activity participants for the reporting period, including individuals who attended events multiple times, was 441.

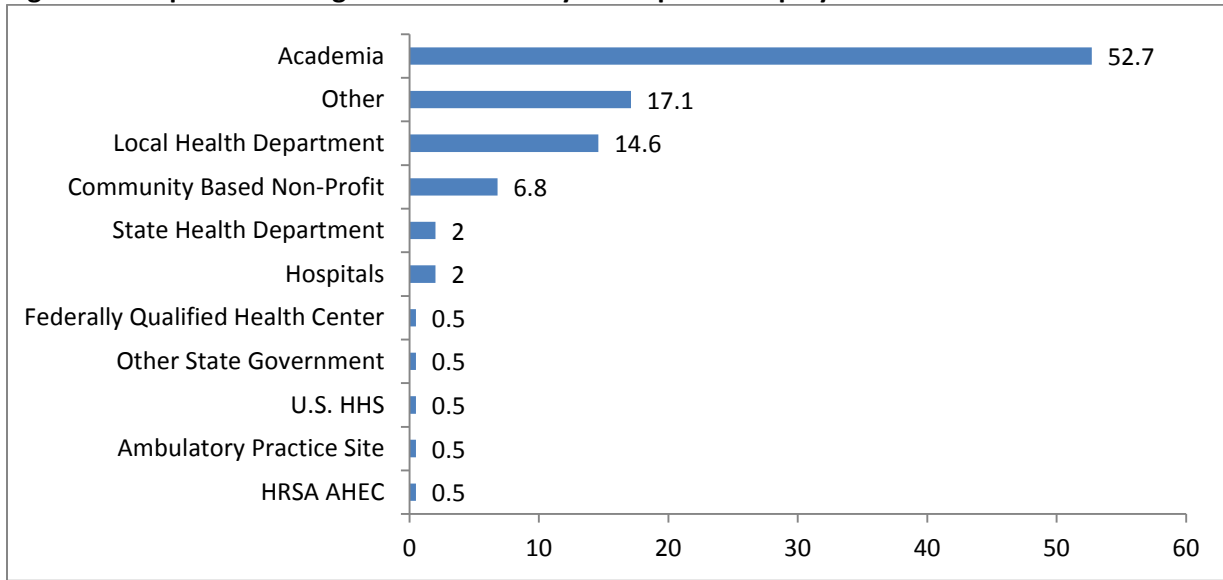
**Figure 6. Total Participants**

Total continuing Education Activity Participants	Unique experiential activity participants	Total activity participants
429	12	441

### Unique Continuing Education Activity Participant Professional Information

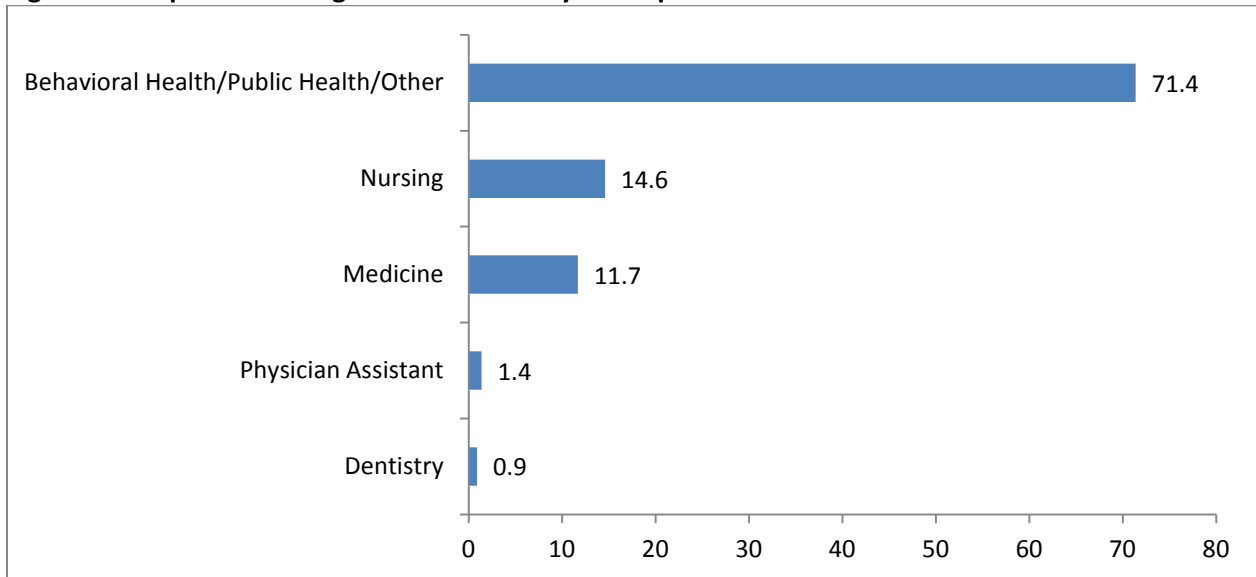
Continuing education activity participants were asked to describe where they were employed, and what their professions were. A total of 205 unique continuing education activity participants responded to this question. The largest segment of respondents, 53%, indicated that they worked in academia (n=108) (see Figure 7). This includes both students as well as faculty/staff. Approximately 17% of respondents were in the “Other” category (n=35), and included individuals employed with private businesses, behavioral health services, national non-profit organizations, exchange students, the self-employed, and those who indicated they were unemployed. It should be noted that employment location categories used in the evaluation survey differed from those of the Year 1 survey, so comparison is not possible.

**Figure 7. Unique Continuing Education Activity Participants: Employment Location**



Trainees were also asked what professions they were, from a range of both general professional categories (dentistry, medicine, physician assistant, nursing, behavioral health/public health/other) and more specific professions under those categories. A total of 213 unique continuing education trainees responded to this question. The largest professional category was behavioral health/public health/other at 71.4% (n=152) (see Figure 8).

**Figure 8. Unique Continuing Education Activity Participants: Professions**



Unique continuing education trainees were asked to identify applicable sub-categories of professions within each of the more general categories. Trainees were also able to choose multiple sub-categories (see Figures 9-13).

**Figure 9. Unique Continuing Education Activity Participants: Dental Professions**

<b>Dentistry</b>	
Dentist - Dental Hygiene	1
Dentist - General	1
Dentist - Public Health	1
Dentist - Other	4

**Figure 10. Unique Continuing Education Activity Participants: Medical Professions**

<b>Medicine</b>	
Medicine – Behavioral/Mental Health	1
Medicine – Family	3
Medicine – General Internal	4
Medicine – General Pediatrics	2
Medicine – General Preventive	2
Medicine – General Preventive/Public Health	4
Medicine – Geriatric	1
Medicine – Integrative	1
Medicine – Internal/General Pediatrics	2
Medicine – Internal/Family	1
Medicine – Obstetrics/Gynecology	3
Medicine – Pediatrics/Family	2
Medicine – Pharmacy	1
Medicine – Podiatry	1
Medicine – Other	11 (e.g. Cardiology, ophthalmology, urgent care)

**Figure 11. Unique Continuing Education Activity Participants: Nursing Professions**

<b>Nursing</b>	
Nursing – Clinical Specialist - Neonatal	1
Nursing – Clinical Specialist – Women’s Health	1
Nursing – Clinical Specialist – Licensed Practical / Vocational (LPN/VN)	1
Nursing – Nurse Practitioner – Psychiatric / Mental Health	1
Nursing – Nurse Practitioner – Adult Gerontology	1
Nursing – Nurse Practitioner – Geropsychiatric	1
Nursing – Administrator	2
Nursing – Educator	8
Nursing – Generalist	1
Nursing – Researcher / Scientist	5
Nursing – Public Health	15
Nursing – Registered Nurse (RN)	16
Nursing – Registered Nurse Student	1
Nursing – Other	4 (LPN-C, Master’s students)

**Figure 12. Unique Continuing Education Activity Participants: Behavioral Health Professions**

<b>Behavioral Health</b>	
Behavioral Health – Clinical Psychology	1
Behavioral Health – Clinical Social Work	2
Behavioral Health – Marriage and Family Therapy	1
Behavioral Health – Other Psychology	2
Behavioral Health – Other Social Work	4
Behavioral Health – Substance Abuse / Addictions	8
Behavioral Health – Other	9 (Behavioral health outreach, NAMI worker, diabetes education)

**Figure 13. Unique Continuing Education Activity Participants: Public Health Professions**

<b>Public Health</b>	
Public Health – Biostatistics	13
Public Health – Community Health Worker	9
Public Health – Environmental – Health Planning	4
Public Health – Environmental – Sciences	4
Public Health – Environmental – Industrial Hygiene	1
Public Health – Environmental – Occupational safety and health	2
Public Health – Environmental – Toxicology	2
Public Health – Environmental – Water quality	3
Public Health – Environmental – Epidemiology	14
Public Health – Environmental – Geriatrics / Aging Populations	3
Public Health – Environmental – Global / International Health	1
Public Health – Education / Behavior – Behavioral sciences	4
Public Health – Education / Behavior – Community health sciences	15
Public Health – Education / Behavior – Evaluation research	4
Public Health – Education / Behavior – Health behavior	14
Public Health – Education / Behavior – Health promotion / disease prevention	32
Public Health – Health services research	14
Public Health – Health Services / Hospital Administration – Health management	9
Public Health – Health Services / Hospital Administration – Health planning	3
Public Health – Health Services / Hospital Administration – Hospital administration	4
Public Health – Maternal & Child Health – Adolescent health	9
Public Health – Maternal & Child Health – Infant	13

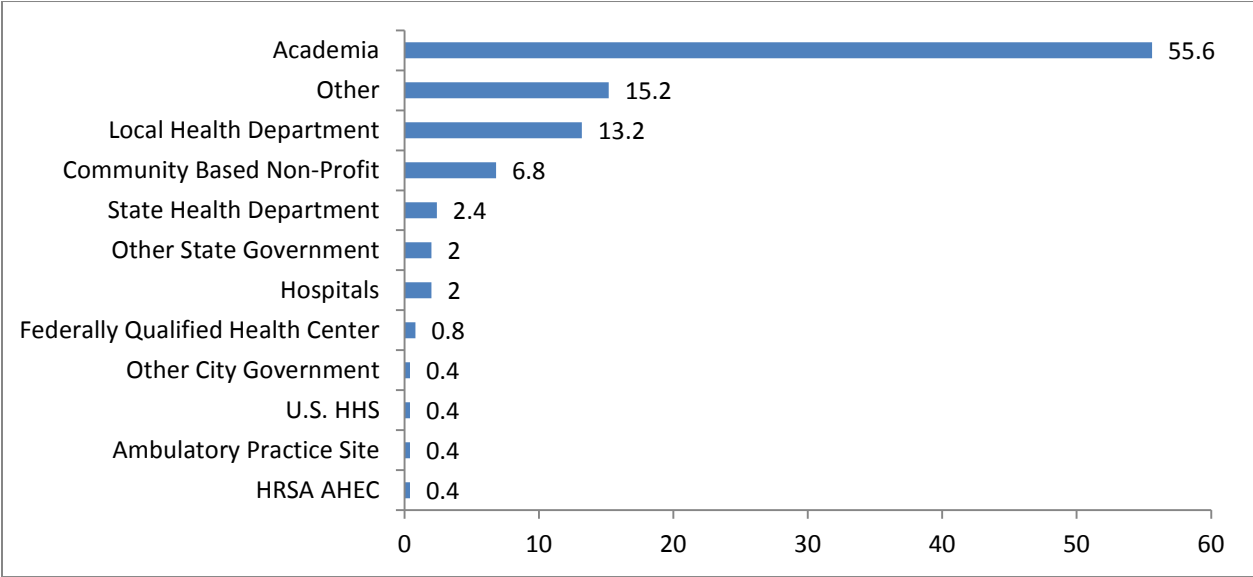


and child health	
Public Health – Maternal & Child Health – Women’s health	9
Public Health – Nutrition – Dietetics	3
Public Health – Nutrition – Public health nutrition	8
Public Health – Occupational Health	4
Public Health – Public Health (general studies)	18
Public Health – Practice – Community health practice	17
Public Health – Practice – Program management	15
Public Health – Urban Health	1
Public Health – Other	19 (Bioethics, Disability, Refugee health, Business administration)

**Total Continuing Education Activity Participant Professional Information**

Professional information for all continuing education activity participants, including individuals who are counted multiple times, is presented below (see Figure 14). Information was collected from 250 activity participants. This profile thus represents the professional backgrounds of all activity participants who participated in continuing education activities who responded to this survey item. When asked where they were employed, the largest category was again academia at 55.6% (n=139).

**Figure 14. Total Continuing Education Activity Participants: Employment Location**



All continuing education trainees were asked to identify applicable sub-categories of professions within each of the more general categories. Trainees were also able to choose multiple sub-categories, and responses include all trainees who attended all continuing education activity events, including those who attended multiple times (see Figures 15-19).

**Figure 15. Total Continuing Education Activity Participants: Dental Professions**

<b>Dentistry</b>	
Dentist - Dental Hygiene	2
Dentist - General	1
Dentist - Public Health	1
Dentist - Other	4

**Figure 16. Total Continuing Education Activity Participants: Medical Professions**

<b>Medicine</b>	
Medicine – Behavioral/Mental Health	1
Medicine – Family	3
Medicine – General Internal	4
Medicine – General Pediatrics	2
Medicine – General Preventive	3
Medicine – General Preventive/Public Health	4
Medicine – Geriatric	1
Medicine – Integrative	1
Medicine – Internal/General Pediatrics	2
Medicine – Internal/Family	1
Medicine – Obstetrics/Gynecology	3
Medicine – Pediatrics/Family	2
Medicine – Pharmacy	1
Medicine – Podiatry	1
Medicine – Other	11 (e.g. Cardiology, ophthalmology, urgent care)

**Figure 17. Total Continuing Education Activity Participants: Nursing Professions**

<b>Nursing</b>	
Nursing – Clinical Specialist - Neonatal	2
Nursing – Clinical Specialist – Women’s Health	1
Nursing – Clinical Specialist – Licensed Practical / Vocational (LPN/VN)	1
Nursing – Nurse Practitioner – Psychiatric / Mental Health	1
Nursing – Nurse Practitioner – Adult Gerontology	1
Nursing – Nurse Practitioner – Geropsychiatric	1
Nursing – Administrator	2
Nursing – Educator	9
Nursing – Generalist	1
Nursing – Researcher / Scientist	6
Nursing – Public Health	16
Nursing – Registered Nurse (RN)	16
Nursing – Registered Nurse Student	1
Nursing – Other	4 (LPN-C, Master’s students)

**Figure 18. Total Continuing Education Activity Participants: Behavioral Health Professions**

<b>Behavioral Health</b>	
Behavioral Health – Clinical Psychology	1
Behavioral Health – Clinical Social Work	2
Behavioral Health – Marriage and Family Therapy	1
Behavioral Health – Other Psychology	2
Behavioral Health – Other Social Work	4
Behavioral Health – Substance Abuse / Addictions	9
Behavioral Health – Other	10 (Behavioral health outreach, NAMI worker, diabetes education)

**Figure 19. Total Continuing Education Activity Participants: Public Health Professions**

<b>Public Health</b>	
Public Health – Biostatistics	18
Public Health – Community Health Worker	9
Public Health – Environmental – Health Planning	4
Public Health – Environmental – Sciences	4
Public Health – Environmental – Industrial Hygiene	3
Public Health – Environmental – Occupational safety and health	3
Public Health – Environmental – Toxicology	2
Public Health – Environmental – Water quality	3
Public Health – Environmental – Epidemiology	18
Public Health – Environmental – Geriatrics / Aging Populations	4
Public Health – Environmental – Global / International Health	1
Public Health – Education / Behavior – Behavioral sciences	7
Public Health – Education / Behavior – Community health sciences	17
Public Health – Education / Behavior – Evaluation research	6
Public Health – Education / Behavior – Health behavior	15
Public Health – Education / Behavior – Health promotion / disease prevention	37
Public Health – Health services research	21
Public Health – Health Services / Hospital Administration – Health management	13
Public Health – Health Services / Hospital Administration – Health planning	3
Public Health – Health Services / Hospital Administration – Hospital administration	6
Public Health – Maternal & Child Health – Adolescent health	12
Public Health – Maternal & Child Health – Infant	15

and child health	
Public Health – Maternal & Child Health – Women’s health	12
Public Health – Nutrition – Dietetics	3
Public Health – Nutrition – Public health nutrition	9
Public Health – Occupational Health	6
Public Health – Public Health (general studies)	21
Public Health – Practice – Community health practice	20
Public Health – Practice – Program management	18
Public Health – Urban Health	2
Public Health – Other	22 (Bioethics, Disability, Refugee health, Business administration)

**Self-Assessment of Participant Competencies, Total Unique Participants**

For total unique participants (n=332), 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 3.53, and the lowest was tribal health skills at 2.29 (see Figure 20). It should be noted that this information was collected among all unique participants at the earliest point within the reporting year for which competency data was available.

**Figure 20. Public Health Competency Domains**



## 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 Figures 21-30 below.

**Figure 21. Analytic/Assessment Competencies**

<b>Analytic/Assessment Skills Overall Domain Mean (n=231)</b>	<b>3.36</b>
Identify the health status of populations and their related determinants of health and illness	3.44
Describe the characteristics of a population-based health problem	3.43
Use variables that measure public health conditions	3.21
Use methods and instruments for collecting valid and reliable quantitative and qualitative data	3.21
Identify sources of public health data and information	3.55
Recognize the integrity and comparability of data	3.34
Identify gaps in data sources	3.30
Adhere to the application of ethical principles in the collection, maintenance, use, and dissemination of data and information	3.60
Describe the public health applications of quantitative and qualitative data and collects quantitative and qualitative community data	3.17
Use information technology to collect, store, and retrieve data	3.32
Describe data to address the scientific, political, ethical, and social public health issues	3.42

**Figure 22. Policy Development and Program Planning Competencies**

<b>Policy Development and Program Planning Skills Overall Domain Mean (n=230)</b>	<b>3.20</b>
Gather information relevant to specific public health policy issues	3.45
Describe how policy options can influence public health programs	3.25
Explain the expected outcomes of policy options	3.15
Gather information that will inform policy decisions	3.27
Describe the public health laws and regulations governing public health programs	2.85
Participate in program planning processes	3.48
Incorporate policies and procedures into program plans and structures	3.25
Identify mechanisms to monitor and evaluate programs for their effectiveness and quality	3.19
Demonstrate the use of public health informatics practices and procedures	2.96
Apply strategies for continuous quality improvement	3.18

**Figure 23. Communication Competencies**

<b>Communication Skills Overall Domain Mean (n=230)</b>	<b>3.36</b>
Identify the health literacy of populations served	3.03
Communicate in writing and orally, in person, and through electronic means, with linguistic and cultural proficiency	3.41
Solicit community-based input from individuals and organizations	3.42
Convey public health information through a variety of approaches	3.49
Participate in the development of demographic, statistical, programmatic, and scientific presentations	3.43
Apply communication and group dynamic strategies in interactions with individuals and	3.38

groups

**Figure 24. Cultural Competencies**

<b>Cultural Competency Skills Overall Domain Mean (n=226)</b>	<b>3.53</b>
Incorporate strategies for interacting with persons from diverse backgrounds	3.58
Recognize the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability, and delivery of public health services	3.70
Respond to diverse needs that are the result of cultural differences	3.50
Describe the dynamic forces that contribute to cultural diversity	3.45
Describe the need for a diverse public health workforce	3.68
Participate in the assessment of the cultural competence of the public health organization	3.38

**Figure 25. Community Dimensions of Practice Competencies**

<b>Community Dimensions of Practice Skills Overall Domain Mean (n=224)</b>	<b>3.43</b>
Recognize community linkages and relationships among multiple factors (or determinants) affecting health	3.39
Demonstrate the capacity to work in community-based participatory research efforts	3.21
Identify stakeholders	3.50
Collaborate with community partners to promote the health of the population	3.62
Maintain partnerships with key stakeholders	3.55
Use group processes to advance community involvement	3.45
Describe the role of governmental and non-governmental organizations in the delivery of community health services	3.36
Identify community assets and resources	3.49
Gather input from the community to inform the development of public health policy and programs	3.37
Inform the public about policies, programs, and resources	3.34

**Figure 26. Public Health Science Competencies**

<b>Public Health Science Skills Overall Domain Mean (n=220)</b>	<b>3.09</b>
Describe the scientific foundation of the field of public health	3.04
Identify prominent events in the history of the public health profession	2.97
Relate public health science skills to the Core Public Health Functions and the Ten Essential Services	2.94
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)	3.15
Describe the scientific evidence related to a public health issue, concern, or, intervention	3.16
Retrieve scientific evidence related to a public health issue, concern, or intervention	3.25
Discuss the limitations of research findings	3.16
Describe the laws, regulations, policies and procedures for the ethical conduct of research	2.97
Partner with other public health professionals in building the scientific base of public health	3.18

**Figure 27. Financial Planning and Management Competencies**

<b>Financial Planning and Management Skills Overall Domain Mean (n=218)</b>	<b>3.19</b>
Describe the local, state, and federal public health and health care systems	3.08
Describe the organizational structures, functions, and authorities of local, state, and federal public health agencies	2.96
Adhere to the organization's policies and procedures	3.58
Participate in the development of programmatic budget	3.16
Operate programs within current and forecasted budget constraints	3.18
Identify strategies for determining budget priorities based on federal, state, and local financial contributions	3.03
Report program performance	3.47
Translate evaluation report information into program performance improvement action steps	3.15
Contribute to the preparation of proposals for funding from external sources	3.28
Apply basic human relations skills to internal collaborations, motivation of colleagues, and resolutions of conflicts	3.59
Demonstrate public health informatics skills to improve program and business operations	2.92
Participate in the development of contracts and other agreements for the provision of services	2.96
Describe how cost-effectiveness, cost-benefit, and cost-utility analyses affect programmatic prioritization and decision-making	

**Figure 28. Leadership and Systems Thinking Competencies**

<b>Leadership and Systems Thinking Skills Overall Domain Mean (n=218)</b>	<b>3.40</b>
Incorporate ethical standards of practice as the basis of all interactions with organizations, communities, and individuals	3.70
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	3.34
Identify internal and external problems that may affect the delivery of Essential Public Health Services	3.26
Use individual, team, and organizational learning opportunities for personal and professional development	3.56
Participate in mentoring and peer review or coaching opportunities	3.41
Participate in the measuring, reporting, and continuous improvement of organizational performance	3.35
Describe the impact of changes in the public health system and the larger social, political, or economic environment on organizational practices	3.26

**Figure 29. HIV/AIDS-related Programming Competencies**

<b>HIV/AIDS-related Programming Skills Overall Domain Mean (n=221)</b>	<b>2.90</b>
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	2.90
Properly refer individuals to further information or services for HIV/AIDS	3.03

**Figure 30. Tribal Health Competencies**

<b>Tribal Health Skills Overall Domain Mean (n=218)</b>	<b>2.29</b>
Identify and understand jurisdictional issues involving tribes that may impact delivery of public health services.	2.28
Identify and understand policies that may impact public health among tribal populations.	2.29
Effectively gather data to monitor public health issues affecting tribal populations in Nebraska.	2.32
Implement evidence-based best practices in public health specifically tailored for tribal populations.	2.28

## Post-1 year Impact

Individuals who attended continuing education activity events from Year 1 of the GPPHTC were contacted 1 year after they first participated in training events. Contact information had been collected from these individuals through the use of sign-in sheets. Those individuals were asked to indicate the impact of participating in GPPHTC continuing education activities in the previous year in several different domains: The impacts on a personal level (personal impact), to their organizations (organizational impact), in the area of serving underserved populations (underserved populations/filling service gaps), and provision of health services generally (service impact). Assessment of impact was scored on a scale of 1-5, with 1 meaning “no impact” and 5 meaning “great impact”. Additionally, we also asked those individuals to re-assess their core competencies. Fifty-three individuals responded to our 1 year impact survey.

## Perceptions of Impact after 1 year

The impact survey indicated that in each impact domain, there was an average positive perceived impact (>3) of participating in GPPHTC activities within the past year. The domain with the most perceived impact was in underserved populations/filling service gaps (M=3.48, SD=1.22). In several domains, there were individual items that were significantly higher than others at a .05 level. Figure 31 indicates perceptions of impact across the impact domains, both in individual items as well as an average for each domain. These results indicate that participants overall believed that participating in the GPPHTC activities had a positive impact in a variety of different realms.

**Figure 31. One Year Impact Assessment**

<b>Item</b>	<b>M</b>	<b>SD</b>
<b>Personal Impact (n=47 for all items)</b>	<b>3.32</b>	<b>1.14</b>
Increased my desire for professional development opportunities.	3.79 <sup>a</sup>	1.16
Developed a personal vision or mission for myself.	3.26 <sup>b</sup>	1.26
Used new approaches or skills to meet challenges.	3.17 <sup>b</sup>	1.27
Expanded my scope of professional responsibilities.	3.09 <sup>b</sup>	1.40
<b>Organizational Impact (n=47 for all items)</b>	<b>3.33</b>	<b>1.27</b>
Contributed to new ideas or approaches within my organization.	3.64 <sup>a</sup>	1.24
Contributed to new efforts within my organization aimed at reducing health disparities.	3.38 <sup>b</sup>	1.36



Contributed to overall improvement of my organization accomplishing its core functions.	3.34 <sup>b</sup>	1.39
Trained or mentored others within my organization.	3.21 <sup>bc</sup>	1.44
Influenced organizational policies and/or procedures to improve performance.	3.09 <sup>c</sup>	1.44
<b>Underserved Populations / Filling Service Gaps (n=47 for all items)</b>	<b>3.48</b>	<b>1.22</b>
Made meaningful new connections with organizations that serve underserved communities.	3.60	1.23
Participated in formal or informal training to better provide services to underserved communities.	3.51	1.38
Improved projects or programs to expand health services among underserved community members.	3.34	1.42
<b>Service Impact (n=45 for most items, exceptions noted below)</b>	<b>3.14</b>	<b>1.26</b>
Improved programs or projects for educating people about health issues.	3.47 <sup>a</sup>	1.41
Created capacity for evaluating personal and/or population-based health services. (n=44)	3.36 <sup>a</sup>	1.26
Improved programs or projects aimed at reducing health disparities.	3.36 <sup>a</sup>	1.37
Improved programs or projects for researching new insights and innovative solutions to health problems.	3.33 <sup>ab</sup>	1.46
Improved programs or projects for creating a competent public and personal health care workforce. (n=43)	3.30 <sup>ac</sup>	1.42
Improved programs or projects for investigating health problems in the community.	3.27 <sup>ab</sup>	1.44
Mobilized community partnerships to solve health problems.	3.24 <sup>ab</sup>	1.35
Improved programs or projects for monitoring individual health indicators to identify community-wide health problems.	3.20 <sup>ab</sup>	1.36
Improved policies and plans that support individual and community health efforts.	3.09 <sup>bc</sup>	1.31
Improved programs or projects focused on tribal health needs.	3.00 <sup>bd</sup>	1.41
Improved programs or projects to address HIV/AIDS.	2.87 <sup>de</sup>	1.42
Linked people to needed personal health services.	2.76 <sup>de</sup>	1.48
Improved laws or regulations to protect health and ensure safety.	2.56 <sup>e</sup>	1.36

Note: Within each impact domain, means with the same superscript are not significantly different.

### Impact on Core Competencies after 1 year

The baseline and 1-year competency self-ratings were compared using a MANOVA for each domain, with individual skills within each category as the multivariate dependent variable, and number of events attended as a between groups variable. After one year, the average score of each competency domain increased among the responding participants for 9 of 10 domains. Only one domain showed an average decrease: Analytic/Assessment Skills. It should be noted that none of the post- 1 year changes in average domain competencies were statistically significant, possibly due to small sample size of matched pre/post 1 year respondents. Thus, although there was a general trend showing improvement in competency domains after one year, it cannot be said that the increased self-ratings were not due to chance. Figures 32-41 depicts baseline and post 1 year competencies.

**Figure 32. Post 1 Year Analytic/Assessment Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Analytic/Assessment Skills Overall Domain (n=38)</b>	<b>3.86</b> <b>(0.79)</b>	<b>3.80</b> <b>(1.05)</b>
Identify the health status of populations and their related determinants of health and illness	3.82 (1.05)	3.60 (1.23)
Describe the characteristics of a population-based health problem	3.84 (1.02)	3.84 (1.09)
Use variables that measure public health conditions	3.80 (1.06)	3.80 (1.16)
Use methods and instruments for collecting valid and reliable quantitative and qualitative data	3.80 (1.05)	3.81 (1.24)
Identify sources of public health data and information	3.93 (1.01)	3.93 (1.18)
Recognize the integrity and comparability of data	3.73 (1.10)	3.71 (1.25)
Identify gaps in data sources	3.58 (1.20)	3.78 (1.22)
Adhere to the application of ethical principles in the collection, maintenance, use, and dissemination of data and information	4.29 (0.99)	4.04 (1.24)
Describe the public health applications of quantitative and qualitative data and collects quantitative and qualitative community data	3.76 (1.05)	3.69 (1.18)
Use information technology to collect, store, and retrieve data	3.93 (0.86)	3.73 (1.21)
Describe data to address the scientific, political, ethical, and social public health issues	4.02 (1.03)	3.84 (1.26)

**Figure 33. Post 1 Year Policy Development and Program Planning Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Policy Development and Program Planning Skills Overall Domain (n=36)</b>	<b>3.44</b> <b>(0.85)</b>	<b>3.68</b> <b>(0.99)</b>
Gather information relevant to specific public health policy issues	3.84 (0.95)	3.84 (1.14)
Describe how policy options can influence public health programs	3.41 (1.17)	3.82 (1.15)
Explain the expected outcomes of policy options	3.42 (1.14)	3.68 (1.20)
Gather information that will inform policy decisions	3.76 (0.98)	3.86 (0.98)
Describe the public health laws and regulations governing public health programs	2.93 (1.18)	3.34 (1.06)
Participate in program planning processes	3.60 (1.18)	3.84 (1.22)
Incorporate policies and procedures into program plans and structures	3.50 (1.13)	3.75 (1.24)

Identify mechanisms to monitor and evaluate programs for their effectiveness and quality	3.40 (1.12)	3.70 (1.07)
Demonstrate the use of public health informatics practices and procedures	3.11 (1.09)	3.30 (1.27)
Apply strategies for continuous quality improvement	3.44 (0.92)	3.66 (1.20)

**Figure 34. Post 1 Year Communication Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Communication Skills Overall Domain (n=35)</b>	<b>3.66 (0.81)</b>	<b>3.81 (0.97)</b>
Identify the health literacy of populations served	3.20 (1.05)	3.33 (1.30)
Communicate in writing and orally, in person, and through electronic means, with linguistic and cultural proficiency	3.93 (0.88)	3.86 (1.08)
Solicit community-based input from individuals and organizations	3.50 (1.09)	3.69 (1.33)
Convey public health information through a variety of approaches	3.70 (1.03)	3.88 (1.18)
Participate in the development of demographic, statistical, programmatic, and scientific presentations	3.96 (1.07)	4.19 (1.05)
Apply communication and group dynamic strategies in interactions with individuals and groups	3.70 (1.05)	3.91 (1.09)

**Figure 35. Post 1 Year Cultural Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Cultural Competency Skills Overall Domain (n=35)</b>	<b>3.70 (0.95)</b>	<b>3.98 (0.97)</b>
Incorporate strategies for interacting with persons from diverse backgrounds	3.73 (0.99)	3.91 (1.02)
Recognize the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability, and delivery of public health services	4.00 (1.01)	4.12 (0.98)
Respond to diverse needs that are the result of cultural differences	3.56 (1.16)	3.98 (1.12)
Describe the dynamic forces that contribute to cultural diversity	3.62 (1.11)	3.90 (1.14)
Describe the need for a diverse public health workforce	3.84 (1.04)	4.28 (0.91)
Participate in the assessment of the cultural competence of the public health organization	3.53 (1.12)	3.74 (1.29)

**Figure 36. Post 1 Year Community Dimensions of Practice Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Community Dimensions of Practice Skills Overall Domain (n=33)</b>	<b>3.64</b>	<b>3.83</b>

	<b>(0.97)</b>	<b>(1.08)</b>
Recognize community linkages and relationships among multiple factors (or determinants) affecting health	3.67 (1.04)	3.84 (1.19)
Demonstrate the capacity to work in community-based participatory research efforts	3.56 (1.10)	3.79 (1.26)
Identify stakeholders	3.60 (1.18)	4.12 (1.12)
Collaborate with community partners to promote the health of the population	3.82 (1.09)	3.90 (1.20)
Maintain partnerships with key stakeholders	3.75 (1.16)	4.05 (1.00)
Use group processes to advance community involvement	3.64 (1.21)	3.76 (1.23)
Describe the role of governmental and non-governmental organizations in the delivery of community health services	3.44 (1.32)	3.69 (1.24)
Identify community assets and resources	3.60 (1.14)	3.76 (1.20)
Gather input from the community to inform the development of public health policy and programs	3.62 (1.01)	3.71 (1.26)
Inform the public about policies, programs, and resources	3.69 (1.02)	3.81 (1.23)

**Figure 37. Post 1 Year Public Health Science Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Public Health Science Skills Overall Domain (n=30)</b>	<b>3.70</b> <b>(1.02)</b>	<b>3.86</b> <b>(0.91)</b>
Describe the scientific foundation of the field of public health	3.59 (1.25)	3.79 (1.05)
Identify prominent events in the history of the public health profession	3.43 (1.21)	3.55 (1.17)
Relate public health science skills to the Core Public Health Functions and the Ten Essential Services	3.32 (1.31)	3.59 (1.18)
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)	3.98 (1.09)	4.10 (0.97)
Describe the scientific evidence related to a public health issue, concern, or, intervention	3.68 (1.14)	3.88 (1.11)
Retrieve scientific evidence related to a public health issue, concern, or intervention	4.00 (1.03)	3.95 (1.08)
Discuss the limitations of research findings	3.86 (1.25)	3.98 (1.07)
Describe the laws, regulations, policies and procedures for the ethical conduct of research	3.64 (1.33)	3.90 (1.03)
Partner with other public health professionals in building the scientific base of public health	3.74 (1.14)	4.00 (0.99)

**Figure 38. Post 1 Year Financial Planning and Management Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Financial Planning and Management Skills Overall Domain (n=31)</b>	<b>3.40 (0.96)</b>	<b>3.60 (1.05)</b>
Describe the local, state, and federal public health and health care systems	3.23 (1.16)	3.35 (1.08)
Describe the organizational structures, functions, and authorities of local, state, and federal public health agencies	3.27 (1.15)	3.18 (1.21)
Adhere to the organization's policies and procedures	3.82 (1.11)	3.85 (1.10)
Participate in the development of programmatic budget	3.23 (1.31)	3.53 (1.45)
Operate programs within current and forecasted budget constraints	3.30 (1.23)	3.60 (1.41)
Identify strategies for determining budget priorities based on federal, state, and local financial contributions	3.30 (1.17)	3.58 (1.38)
Report program performance	3.66 (1.18)	3.80 (1.18)
Translate evaluation report information into program performance improvement action steps	3.36 (1.20)	3.88 (1.18)
Contribute to the preparation of proposals for funding from external sources	3.61 (1.22)	3.83 (1.20)
Apply basic human relations skills to internal collaborations, motivation of colleagues, and resolutions of conflicts	3.89 (1.09)	4.03 (0.95)
Demonstrate public health informatics skills to improve program and business operations	3.00 (1.15)	3.35 (1.12)
Participate in the development of contracts and other agreements for the provision of services	3.31 (1.26)	3.59 (1.35)
Describe how cost-effectiveness, cost-benefit, and cost-utility analyses affect programmatic prioritization and decision-making	3.07 (1.07)	3.28 (1.26)

**Figure 39. Post 1 Year Leadership and Systems Thinking Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Leadership and Systems Thinking Skills Overall Domain (n=33)</b>	<b>3.64 (1.06)</b>	<b>4.02 (1.01)</b>
Incorporate ethical standards of practice as the basis of all interactions with organizations, communities, and individuals	3.84 (1.19)	4.00 (1.10)
Describe how public health operates within a larger system	3.69 (1.22)	4.07 (1.21)
Participate with stakeholders in identifying key public health values and a shared public health vision as guiding principles for community action	3.71 (1.25)	4.10 (1.21)
Identify internal and external problems that may affect the delivery of Essential Public Health Services	3.71 (1.18)	4.08 (1.14)
Use individual, team, and organizational learning opportunities for personal and professional development	3.73 (1.02)	4.05 (1.01)
Participate in mentoring and peer review or coaching opportunities	3.64	4.00

	(1.23)	(1.16)
Participate in the measuring, reporting, and continuous improvement of organizational performance	3.44 (1.16)	4.05 (1.11)
Describe the impact of changes in the public health system and the larger social, political, or economic environment on organizational practices	3.38 (1.39)	3.88 (1.22)

**Figure 40. Post 1 Year HIV/AIDS-related Programming Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>HIV/AIDS-related Programming Skills Overall Domain (n=32)</b>	<b>2.74</b> <b>(1.21)</b>	<b>2.83</b> <b>(1.34)</b>
Discuss HIV/AIDS related diagnosis and treatment issues with community members you serve	2.70 (1.26)	2.68 (1.39)
Address stigma issues related to HIV/AIDS within communities you serve	2.77 (1.21)	2.80 (1.40)
Properly refer individuals to further information or services for HIV/AIDS	2.79 (1.34)	3.00 (1.49)

**Figure 41. Post 1 Year Tribal Health Competencies**

Item	Pre-Event	1-Year
	M (SD)	M (SD)
<b>Tribal Health Skills Overall Domain (n=31)</b>	<b>2.65</b> <b>(0.99)</b>	<b>3.20</b> <b>(1.18)</b>
Identify and understand jurisdictional issues involving tribes that may impact delivery of public health services.	2.68 (1.12)	3.10 (1.29)
Identify and understand policies that may impact public health among tribal populations.	2.70 (1.19)	3.23 (1.31)
Effectively gather data to monitor public health issues affecting tribal populations in Nebraska.	2.59 (1.17)	3.28 (1.28)
Implement evidence-based best practices in public health specifically tailored for tribal populations.	2.61 (1.13)	3.18 (1.27)

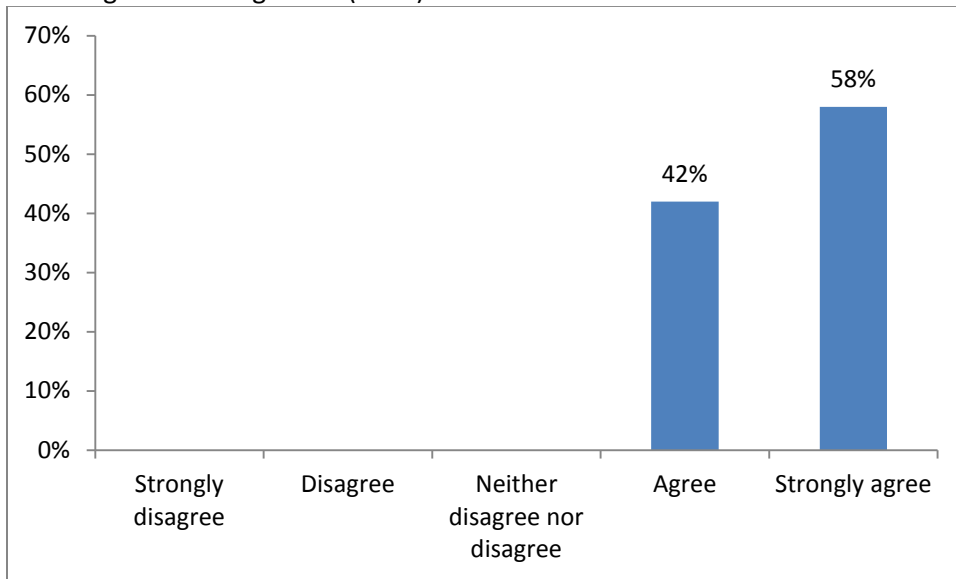
## In-Person, Post-Continuing Education Training Activity Assessments

Following each continuing education activity, participants were asked to assess how much knowledge they gained, and their perceptions of each activity's training length and duration. In summary, 90% of respondents agreed or strongly agreed that their knowledge of the subject matter increased as a result of the trainings (see Figures 42-52). Approximately 80% of respondents believed that the training sessions they participated in were the right length (see Figures 53-63). Approximately 49% of respondents believed that the training sessions were challenging, but not too difficult (see Figures 64-74). Forty six percent (46%) of respondents believed the training sessions were fairly easy. Six percent (6%) believed they were either too easy or too difficult.

## In-Person, Post-Continuing Education Training Activity Assessments: Post-Event Knowledge Gain

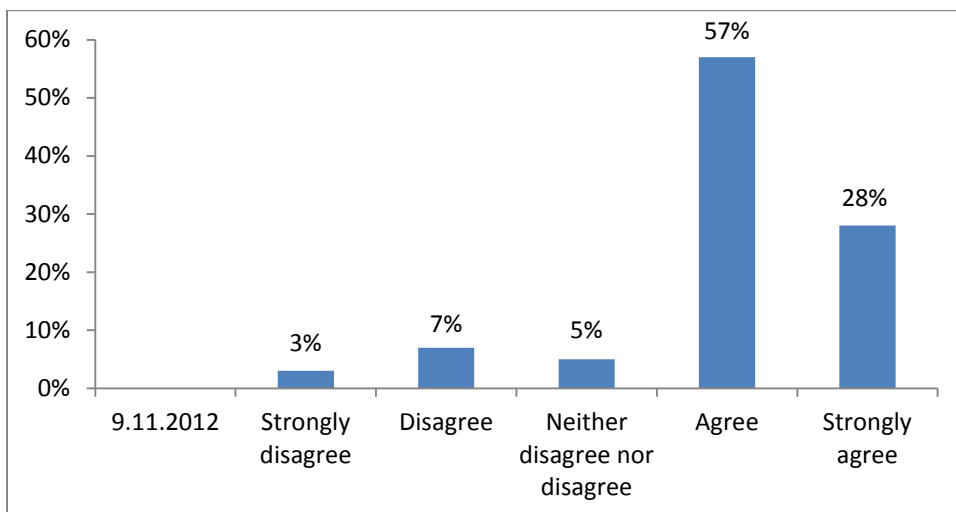
**Figure 42: Knowledge Increase: August 9, 2012 - East Central District Health Department & Good Neighbor Community Health Center Workshop: Five Dysfunctions of a Team**

100% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=19).



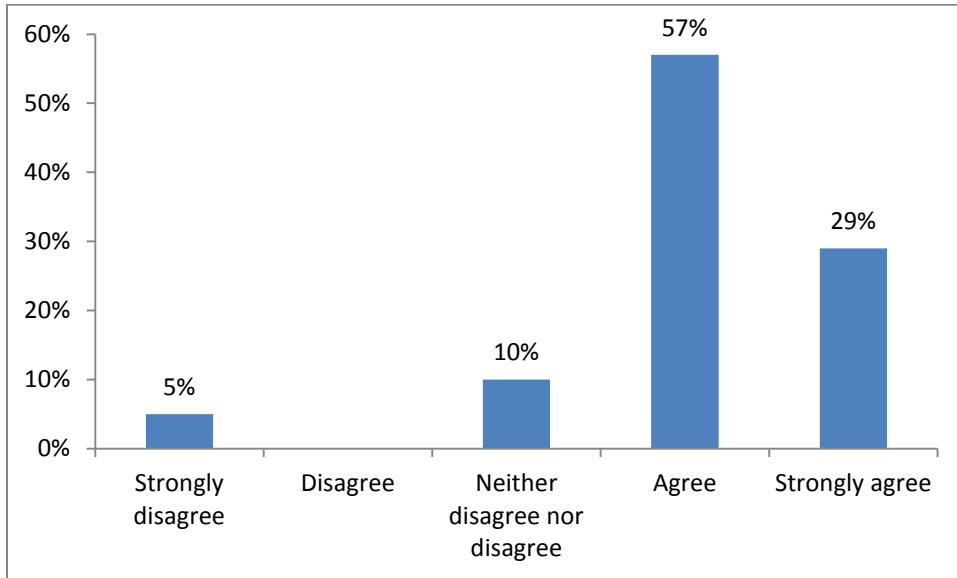
**Figure 43: Knowledge Increase: September 11, 2012 – Implementing the Affordable Care Act: The Current State of Play: Implications of the affordable care act as it relates to Health Care and Public Health**

85% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=60).



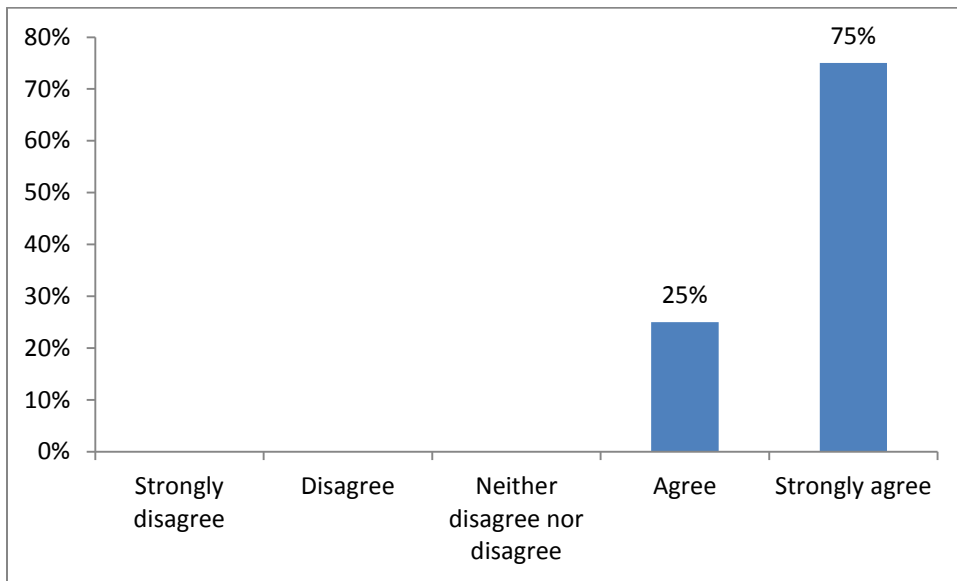
**Figure 44: Knowledge Increase: September 26, 2012 – Priority Areas for Improvement of Quality in Public Health**

86% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=21).



**Figure 45: Knowledge Increase: November 1, 2012 – Health Disparities and Healthy Equity**

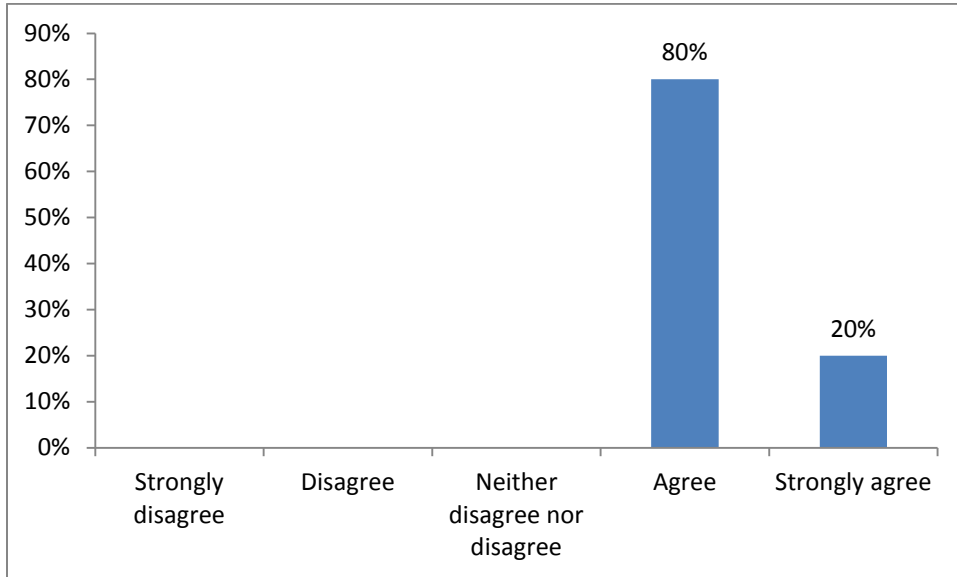
100% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=4).





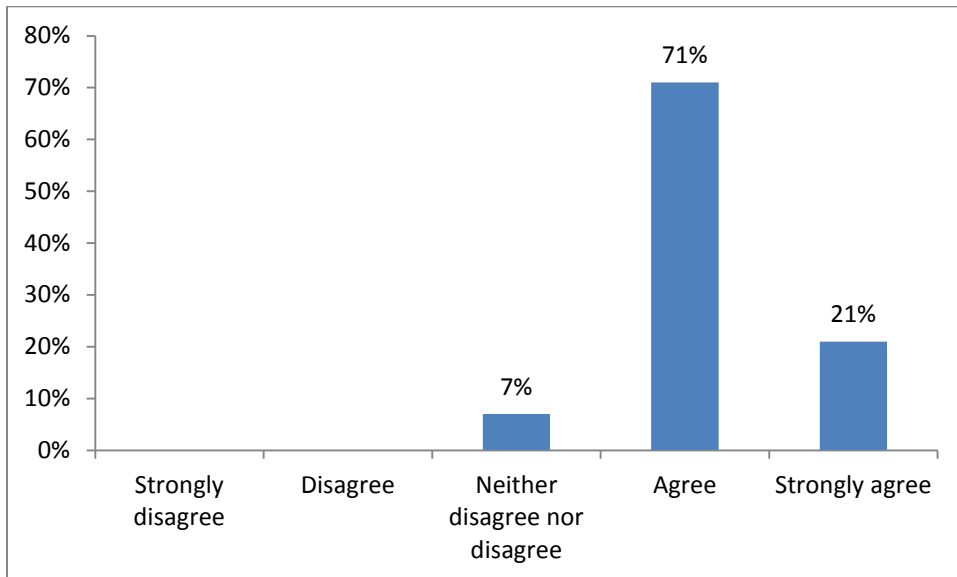
**Figure 46: Knowledge Increase: January 8, 2013 - Moving from Cultural Competence to Cultural Humility: Leadership Needs and Challenges**

100% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=5).



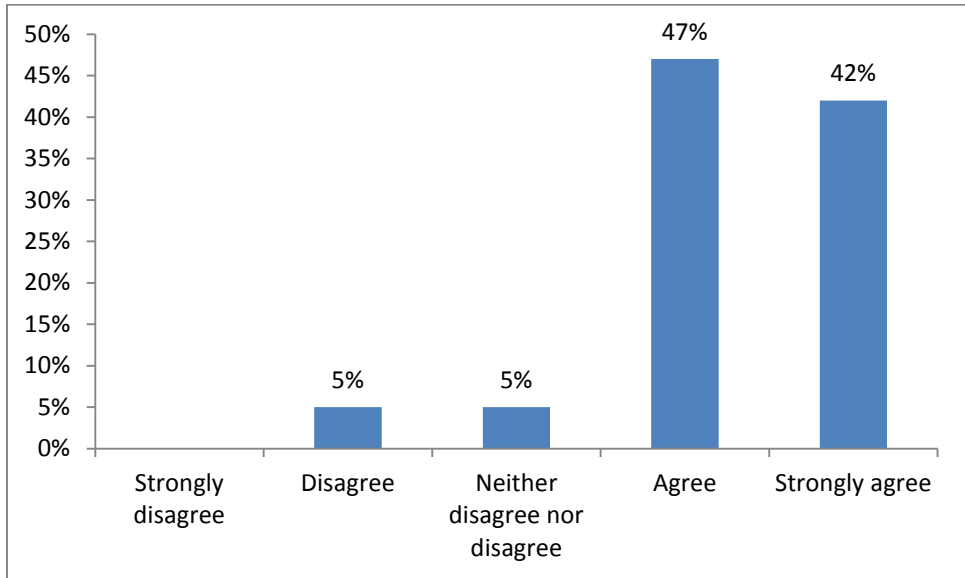
**Figure 47: Knowledge Increase: January 9, 2013 - Cultural Humility versus Cultural Competence: A Critical Distinction**

92% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=42).



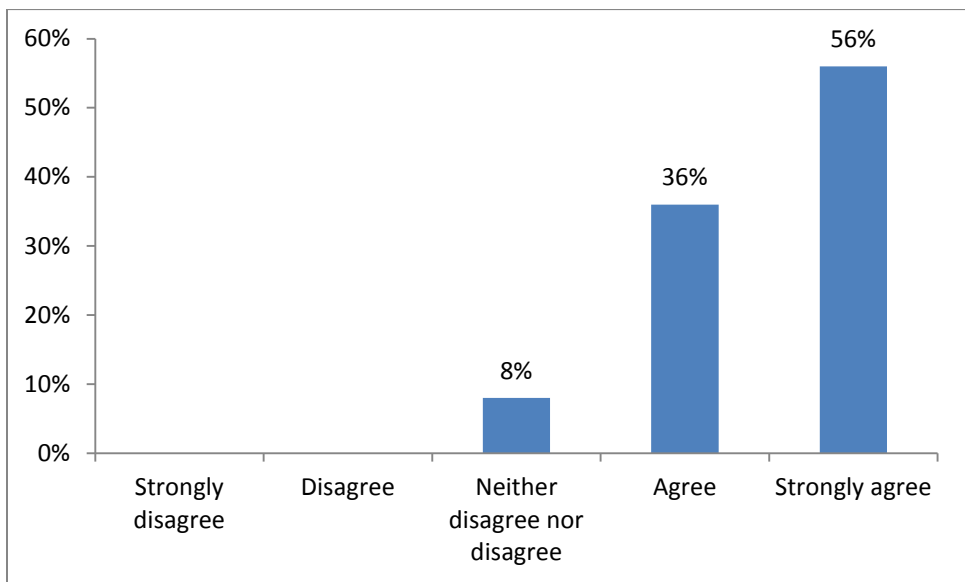
**Figure 48: Knowledge Increase: April 2, 2013 – CPH Grand Rounds: Nebraska Early Hearing Detection and Intervention Program**

89% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=19).



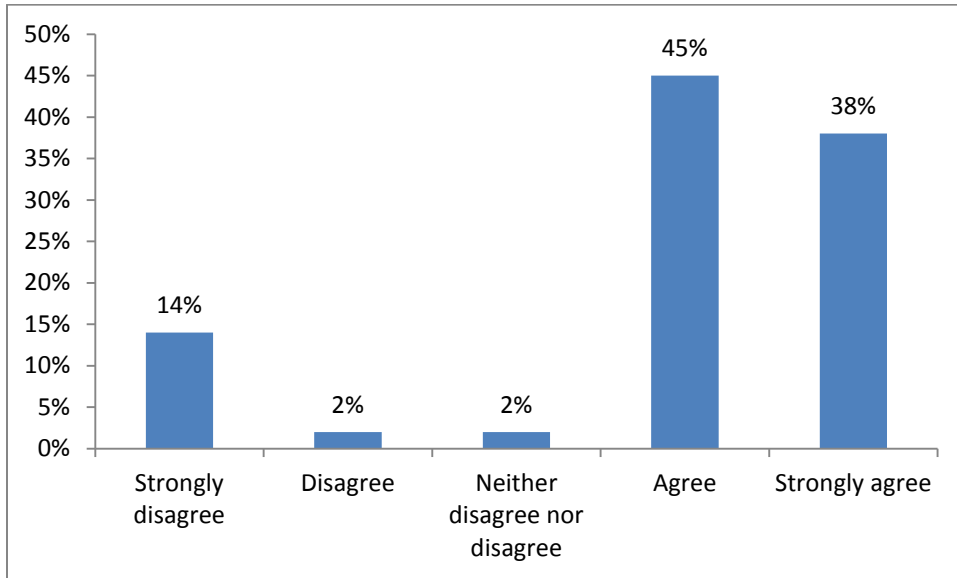
**Figure 49: Knowledge Increase: April 3, 2013 – Preparing for the Zombie Apocalypse or Other Events Slightly More Likely**

92% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=25).



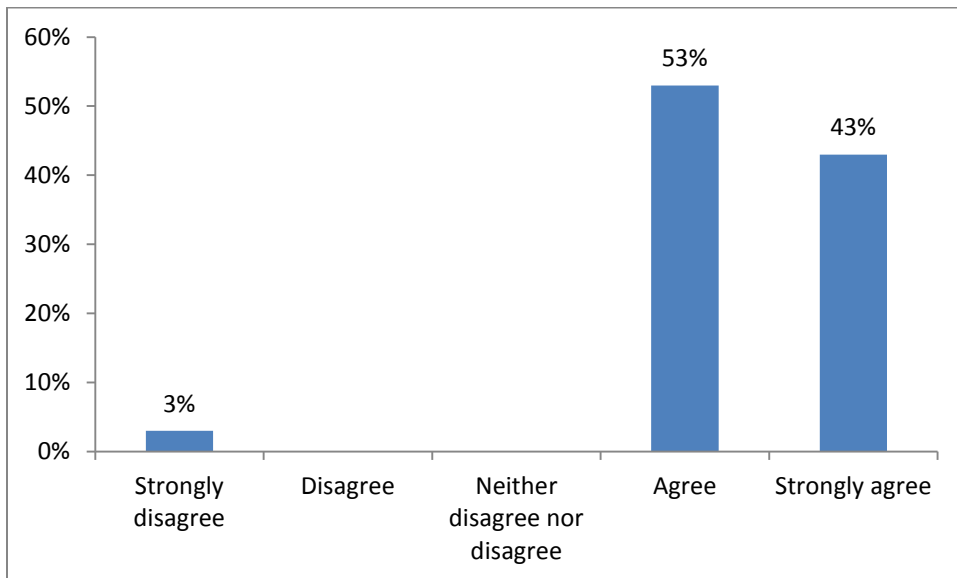
**Figure 50: Knowledge Increase: April 12, 2013 – Achieving Healthy Equity: Addressing the Impacts of Racism on Health**

83% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=58).



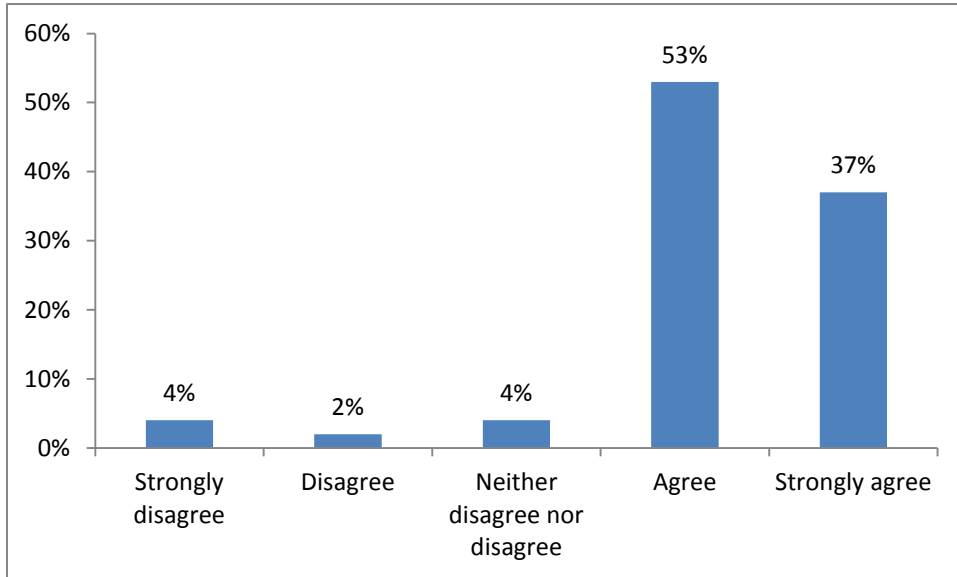
**Figure 51: Knowledge Increase: April 22, 2013 – Public Health Policy Short Course**

96% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following this training event (n=30).



**Figure 52: Knowledge Increase: All In-Person Events**

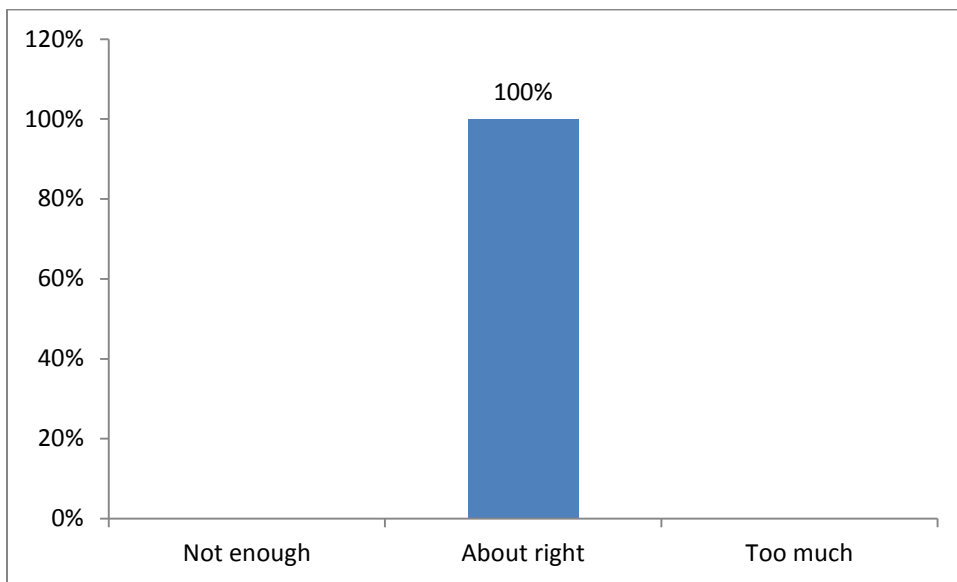
In total, 90% of respondents agreed or strongly agreed that their knowledge of the subject matter increased following the training events convened in Year 2 (n=283).



**In-Person, Post-Continuing Education Training Activity Assessments: Post-Event Perceptions of Training Length**

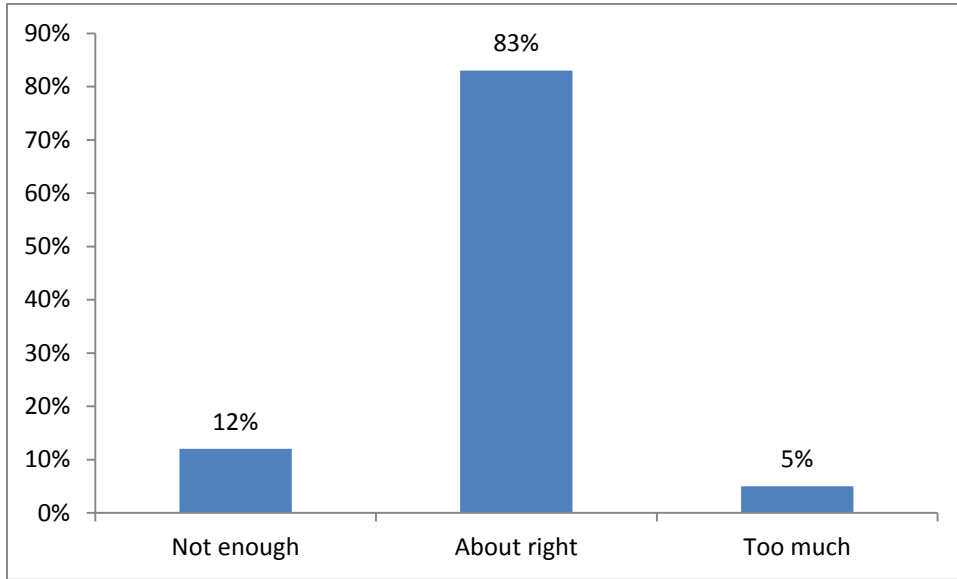
**Figure 53: Training Length: August 9, 2012 - East Central District Health Department & Good Neighbor Community Health Center Workshop: Five Dysfunctions of a Team**

100% of respondents believed the length of this training session was about right (n=19).



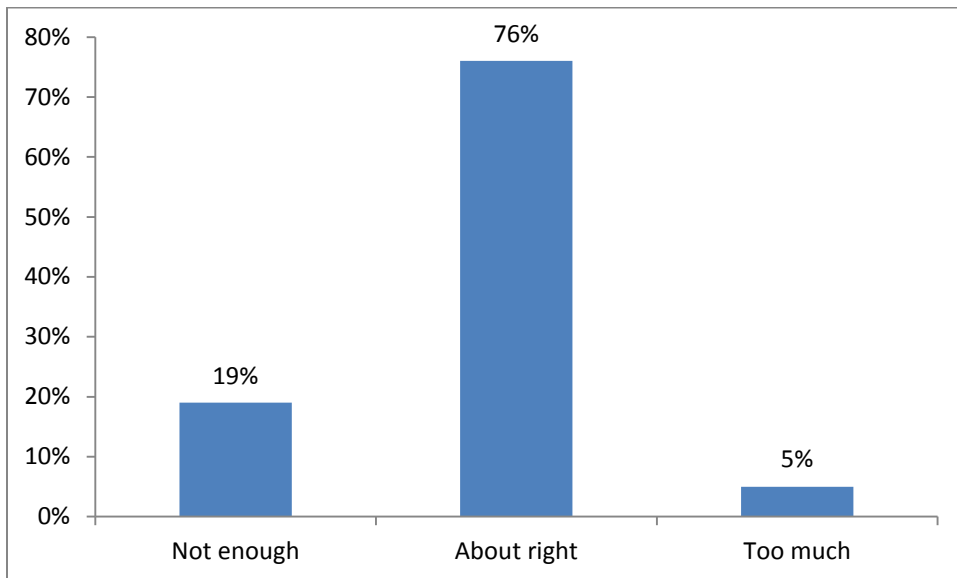
**Figure 54: Training Length: September 11, 2012 – Implementing the Affordable Care Act: The Current State of Play: Implications of the affordable care act as it relates to Health Care and Public Health**

83% of respondents believed the length of this training session was about right (n=59).



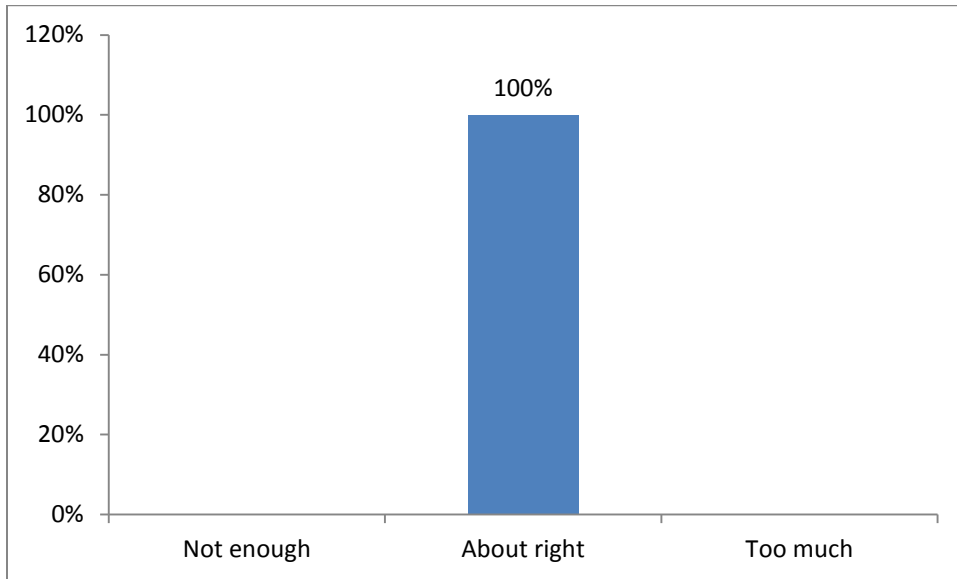
**Figure 55: Training Length: September 26, 2012 – Priority Areas for Improvement of Quality in Public Health**

76% of respondents believed the length of this training session was about right (n=21).



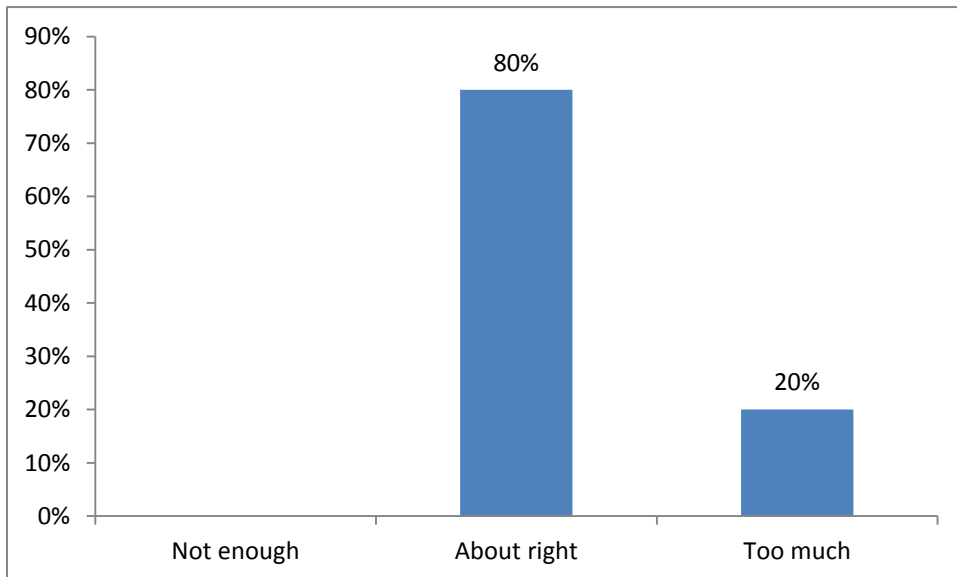
**Figure 56: Training Length: November 1, 2012 – Health Disparities and Healthy Equity**

100% of respondents believed the length of this training session was about right (n=4).



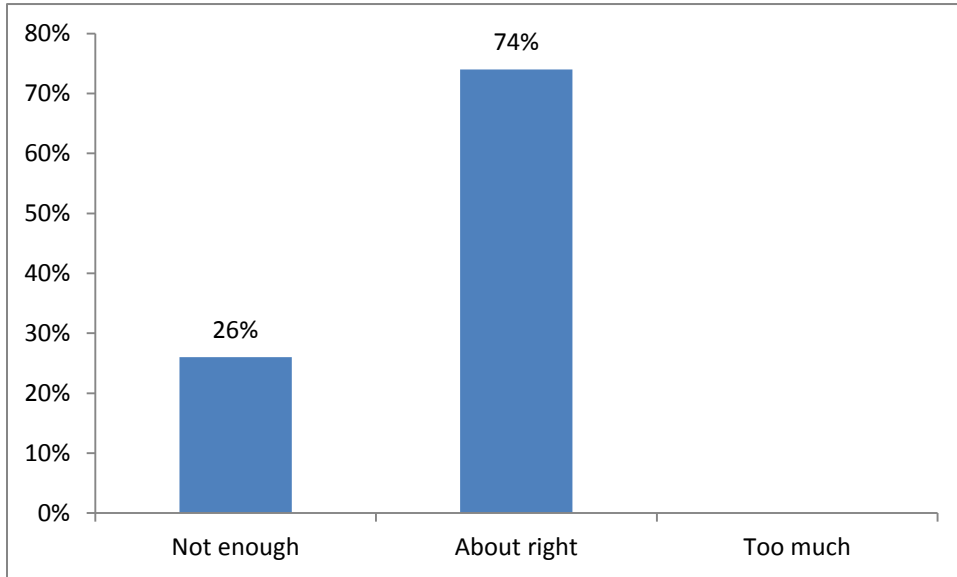
**Figure 57: Training Length: January 8, 2013 - Moving from Cultural Competence to Cultural Humility: Leadership Needs and Challenges**

80% of respondents believed the length of this training session was about right (n=5).



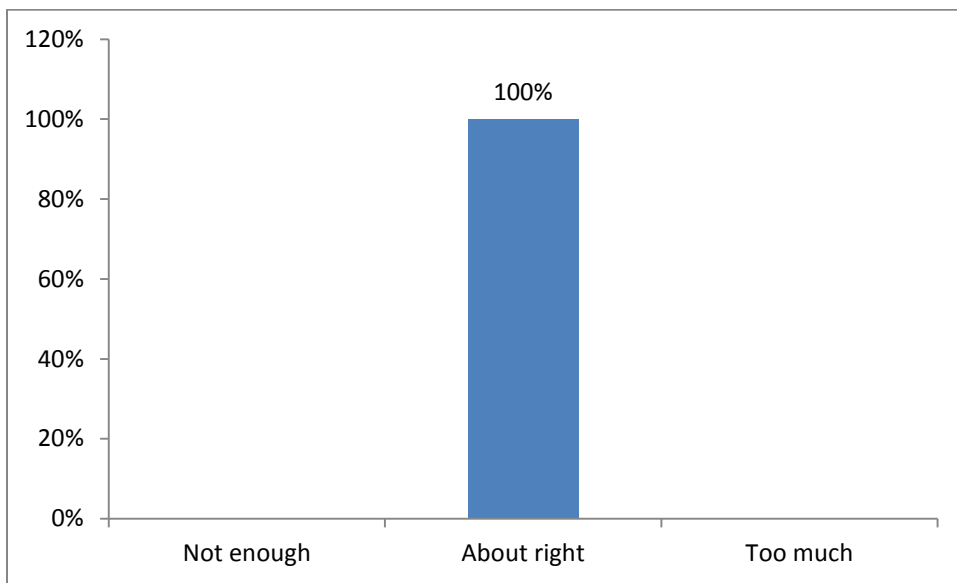
**Figure 58: Training Length: January 9, 2013 - Cultural Humility versus Cultural Competence: A Critical Distinction**

74% of respondents believed the length of this training session was about right (n=42).



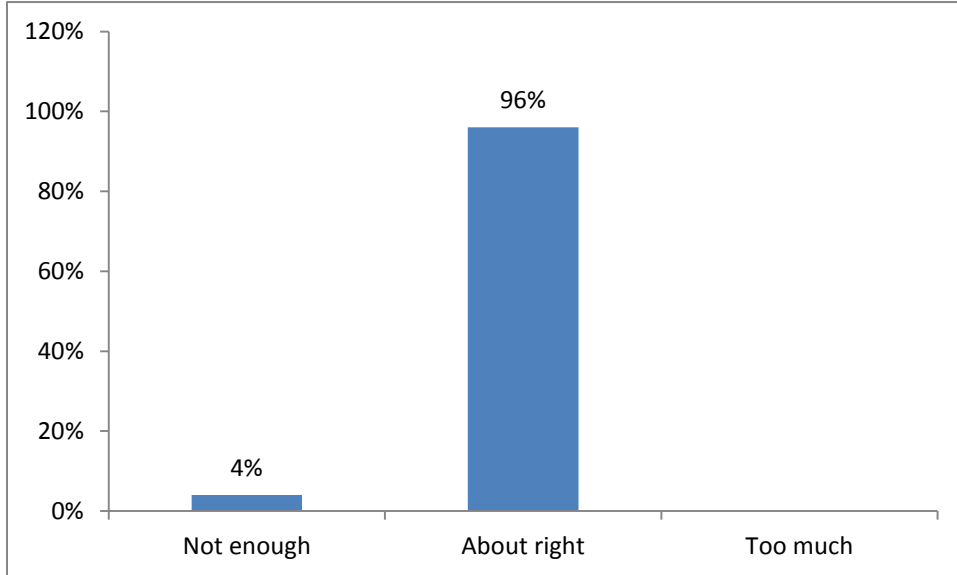
**Figure 59: Training Length: April 2, 2013 – COPH Grand Rounds: Nebraska Early Hearing Detection and Intervention Program**

100% of respondents believed the length of this training session was about right (n=19).



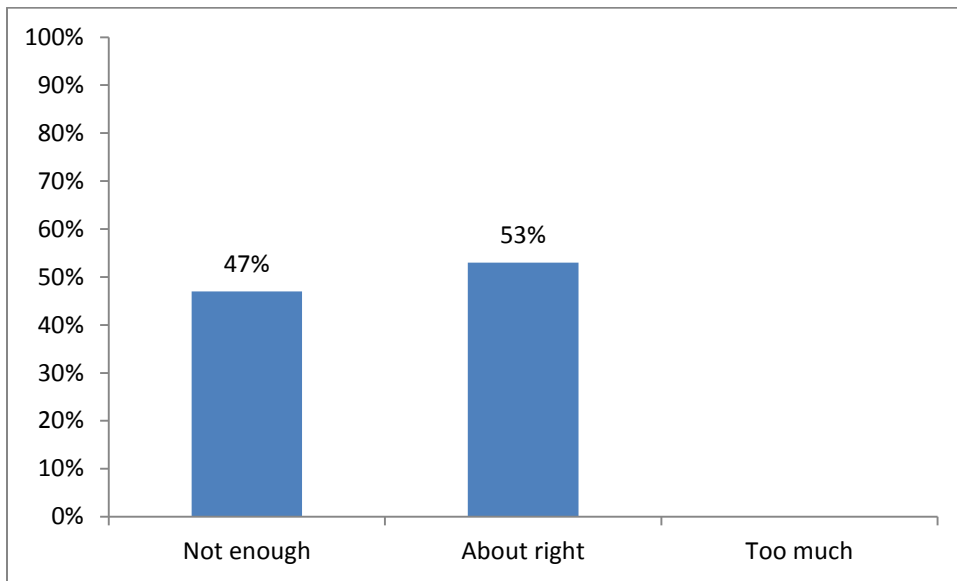
**Figure 60: Training Length: April 3, 2013 – Preparing for the Zombie Apocalypse or Other Events Slightly More Likely**

96% of respondents believed the length of this training session was about right (n=25).



**Figure 61: Training Length: April 12, 2013 – Achieving Healthy Equity: Addressing the Impacts of Racism on Health**

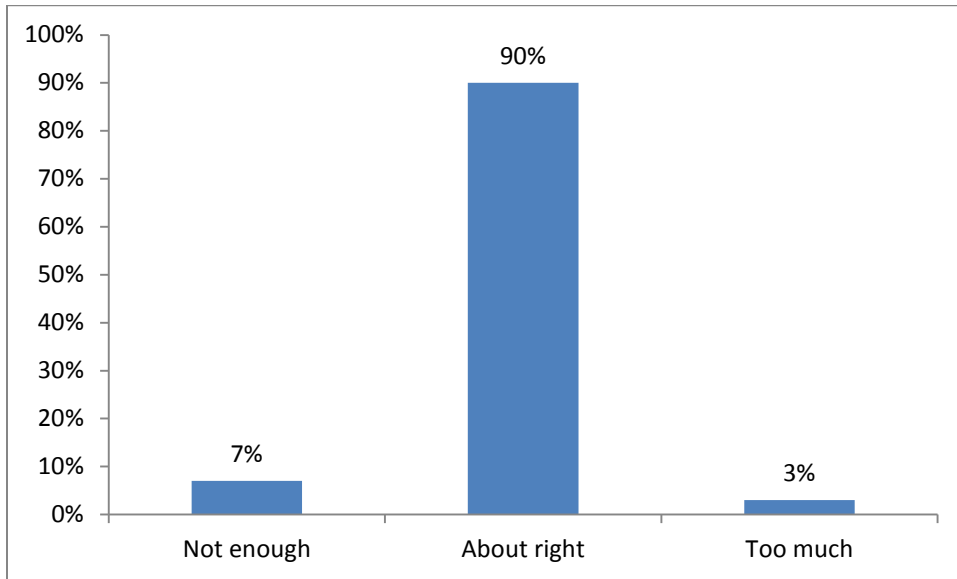
53% of respondents believed the length of this training session was about right (n=57).





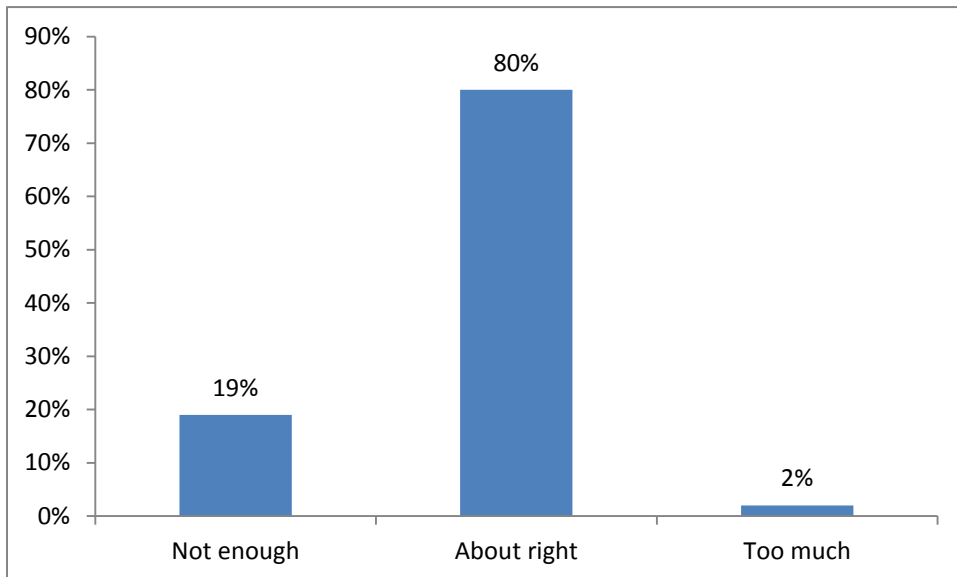
**Figure 62: Training Length: April 22, 2013 – Public Health Policy Short Course**

90% of respondents believed the length of this training session was about right (n=30).



**Figure 63: Training Length: All In-Person Events**

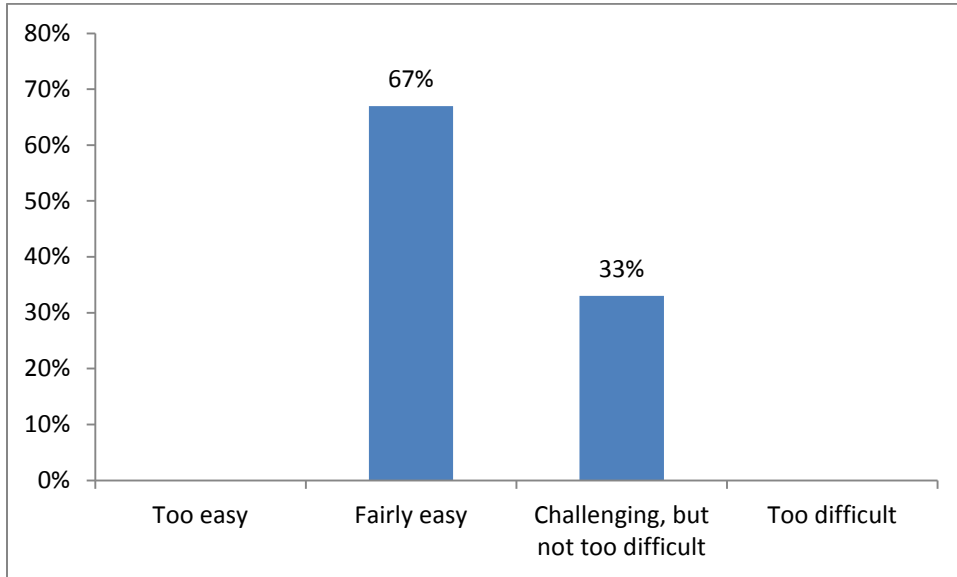
In total, 80% of respondents believed the length of training sessions was about right for continuing education activities convened in Year 2 (n=281).



**In-Person, Post-Continuing Education Training Activity Assessments: Post-Event Perceptions of Training Difficulty**

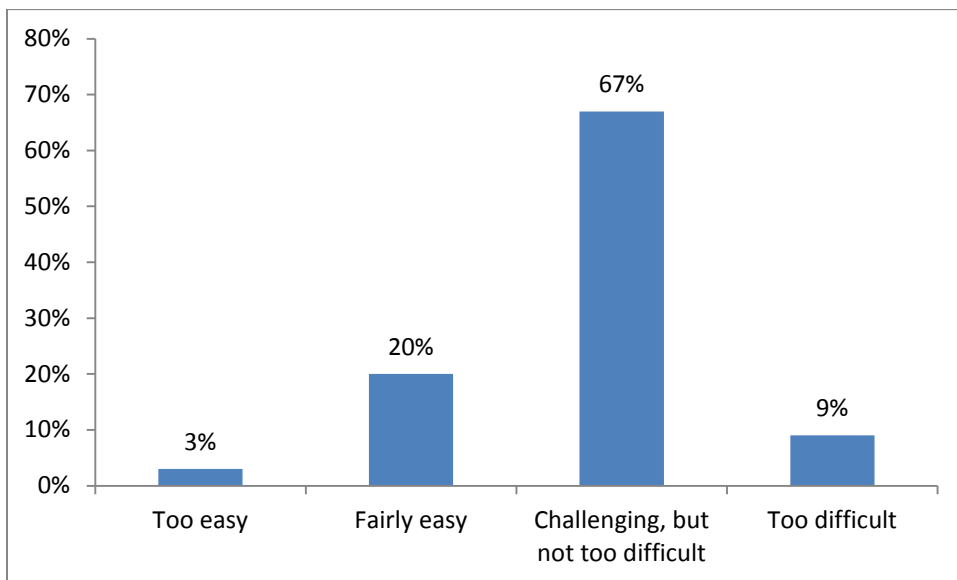
**Figure 64: Training Difficulty: August 9, 2012 - East Central District Health Department & Good Neighbor Community Health Center Workshop: Five Dysfunctions of a Team**

67% of respondents believed the training was fairly easy, and 33% believed it was challenging, but not too difficult (n=18).



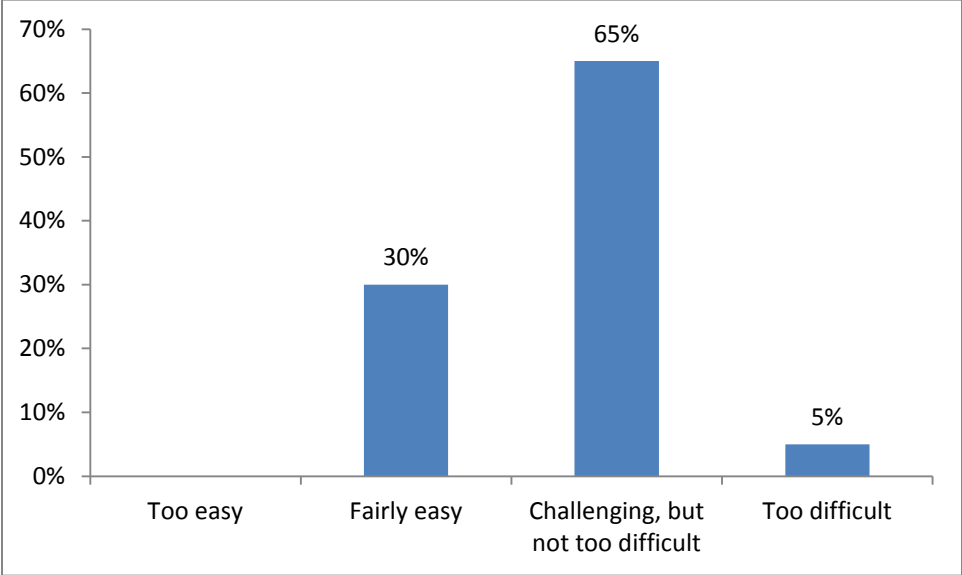
**Figure 65: Training Difficulty: September 11, 2012 – Implementing the Affordable Care Act: The Current State of Play: Implications of the affordable care act as it relates to Health Care and Public Health**

67% believed the training was challenging, but not too difficult, and 20% of respondents believed the training was fairly easy. The remaining 12% believed it was either too easy or too difficult (n=59).



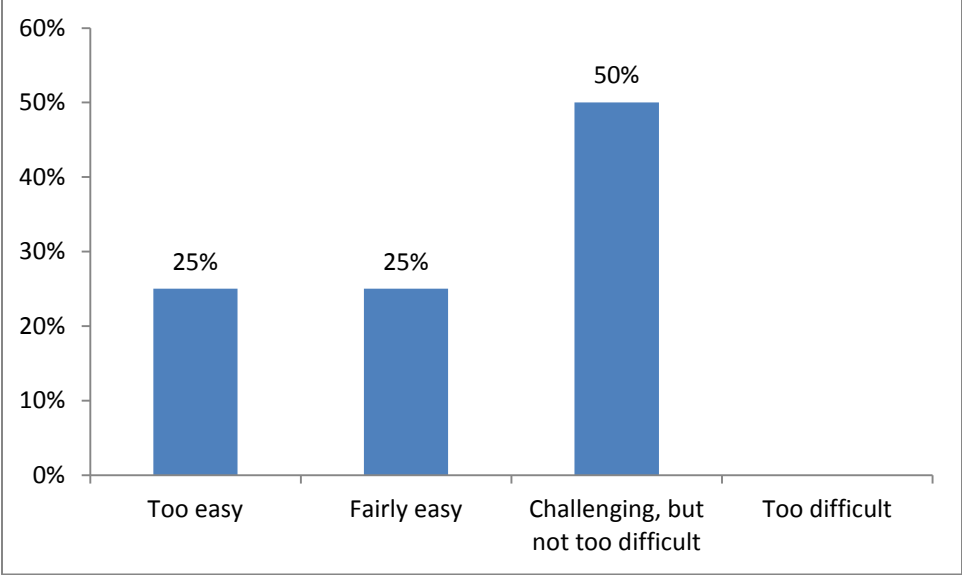
**Figure 66: Training Difficulty: September 26, 2012 – Priority Areas for Improvement of Quality in Public Health**

65% believed the training was challenging, but not too difficult, and 30% of respondents believed the training was fairly easy. The remaining 5% believed it was too difficult (n=20).



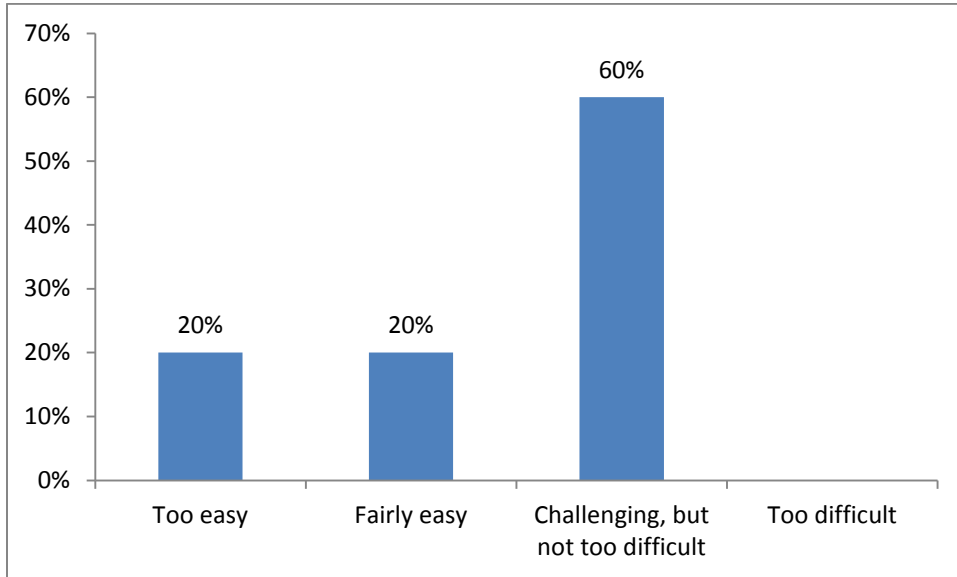
**Figure 67: Training Difficulty: November 1, 2012 – Health Disparities and Healthy Equity**

50% believed the training was challenging, but not too difficult, and 25% of respondents believed the training was fairly easy. The remaining 25% believed it was too easy (n=4).



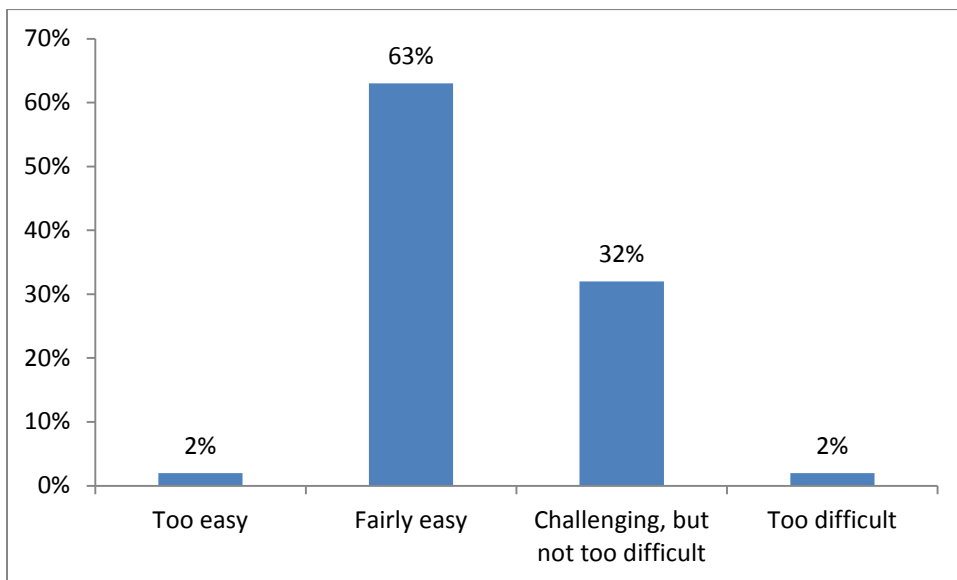
**Figure 68: Training Difficulty: January 8, 2013 - Moving from Cultural Competence to Cultural Humility: Leadership Needs and Challenges**

60% believed the training was challenging, but not too difficult, and 20% of respondents believed the training was fairly easy. The remaining 20% believed it was too easy (n=5).



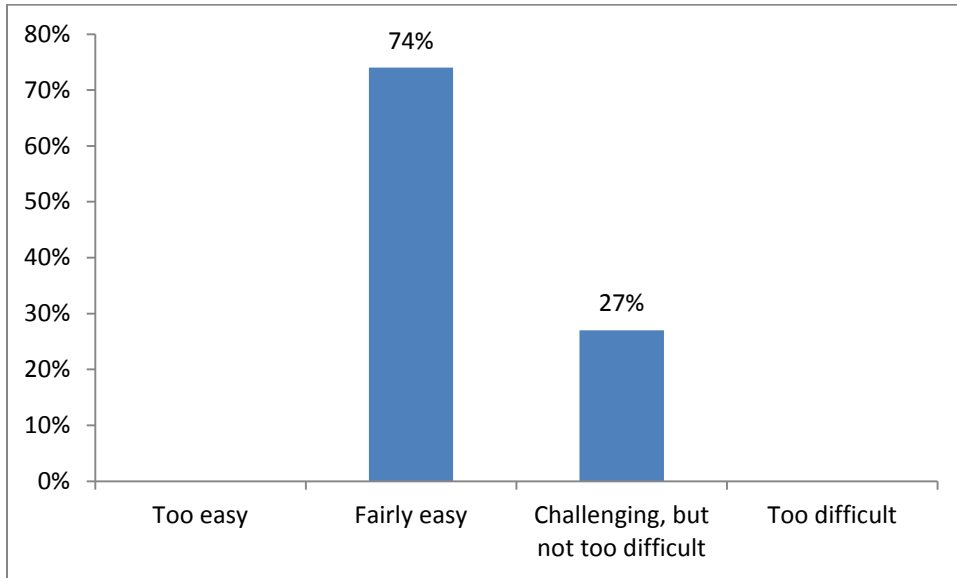
**Figure 69: Training Difficulty: January 9, 2013 - Cultural Humility versus Cultural Competence: A Critical Distinction**

63% believed the training was fairly easy, and 32% of respondents believed the training was challenging, but not too difficult. The remaining 4% believed it was too easy or too difficult (n=41).



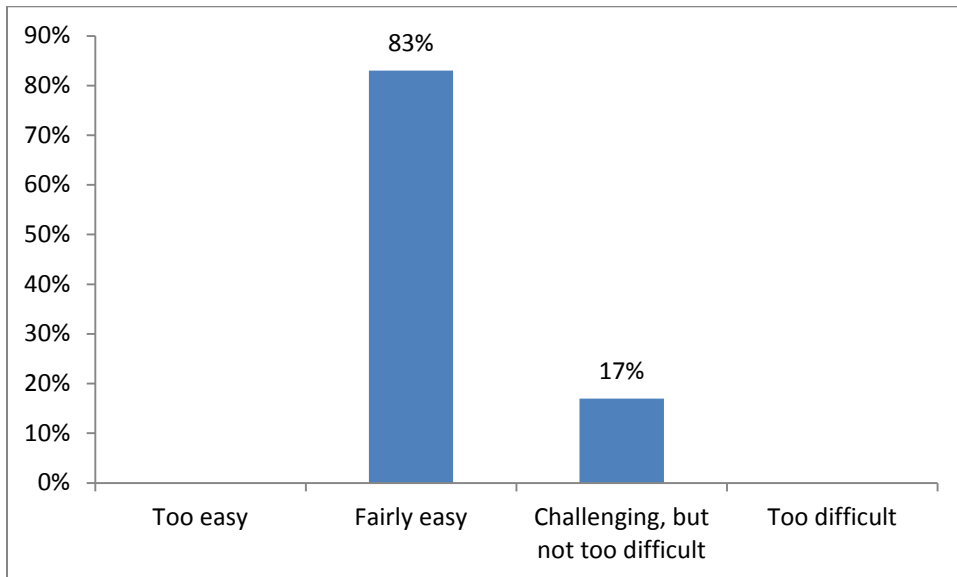
**Figure 70: Training Difficulty: April 2, 2013 – COPH Grand Rounds: Nebraska Early Hearing Detection and Intervention Program**

74% believed the training was fairly easy, and 27% of respondents believed the training was challenging, but not too difficult (n=19).



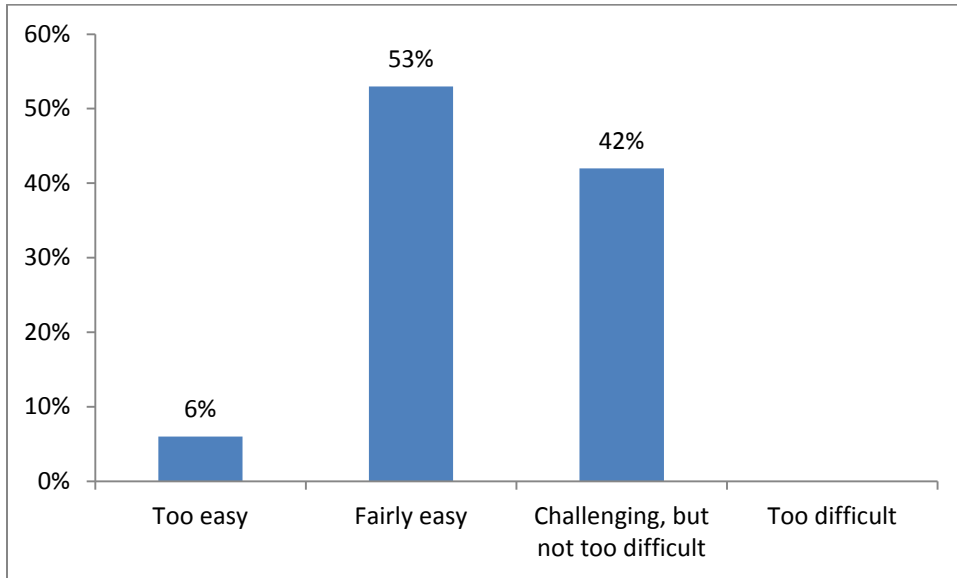
**Figure 71: Training Difficulty: April 3, 2013 – Preparing for the Zombie Apocalypse or Other Events Slightly More Likely**

83% believed the training was fairly easy, and 17% of respondents believed the training was challenging, but not too difficult (n=24).



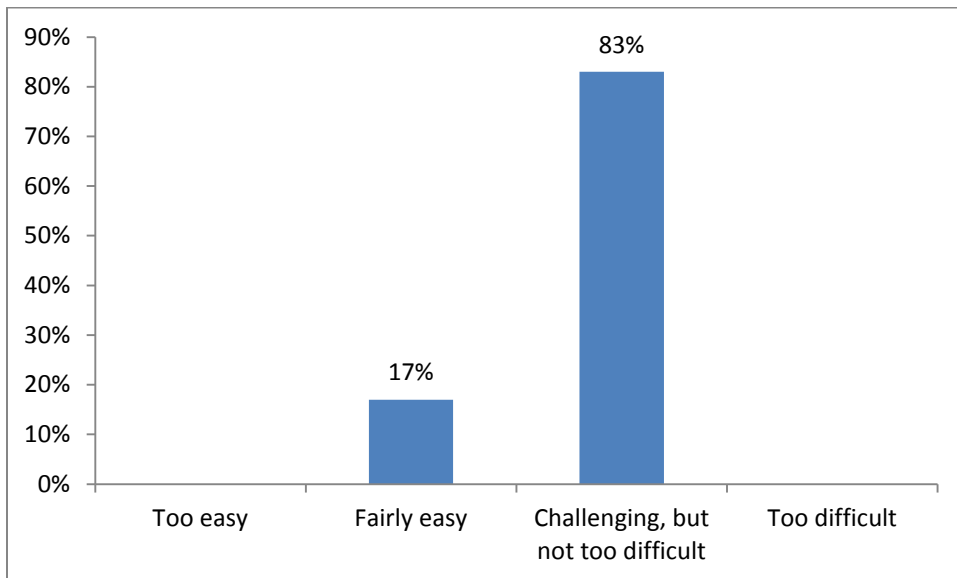
**Figure 72: Training Difficulty: April 12, 2013 – Achieving Healthy Equity: Addressing the Impacts of Racism on Health**

53% believed the training was fairly easy, and 42% believed it was challenging, but not too difficult. The remaining 6% believed it was too easy (n=55).



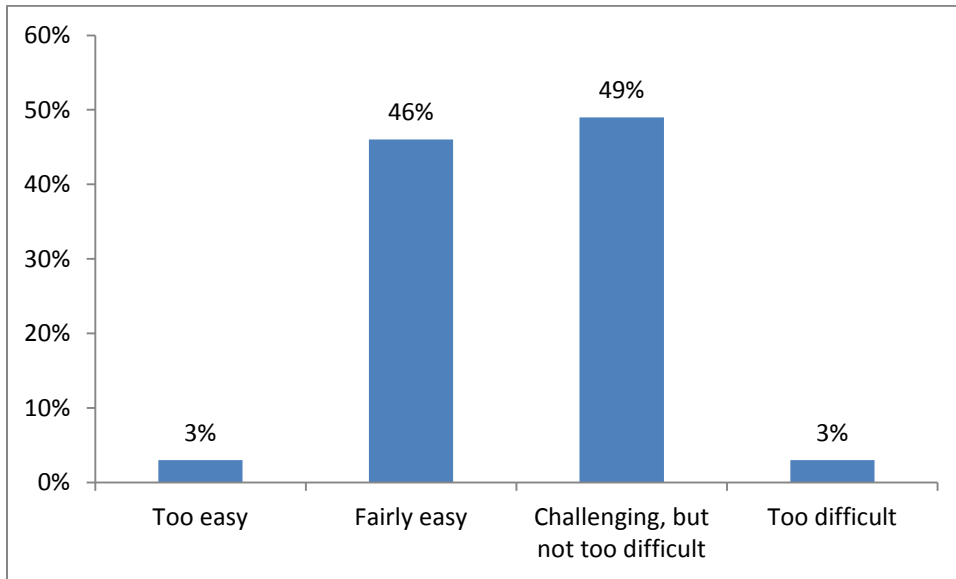
**Figure 73: Training Difficulty: April 22, 2013 – Public Health Policy Short Course**

83% believed the training was challenging, but not too difficult, and 17% of respondents believed the training was fairly easy (n=30).



**Figure 74: Training Difficulty: All In-Person Events**

In total, 49% of respondents believed that training sessions convened in Year 2 were challenging, but not too difficult, and 46% of respondents believed they were fairly easy. The remaining 6% believed that they were either too easy or too difficult (n=275).

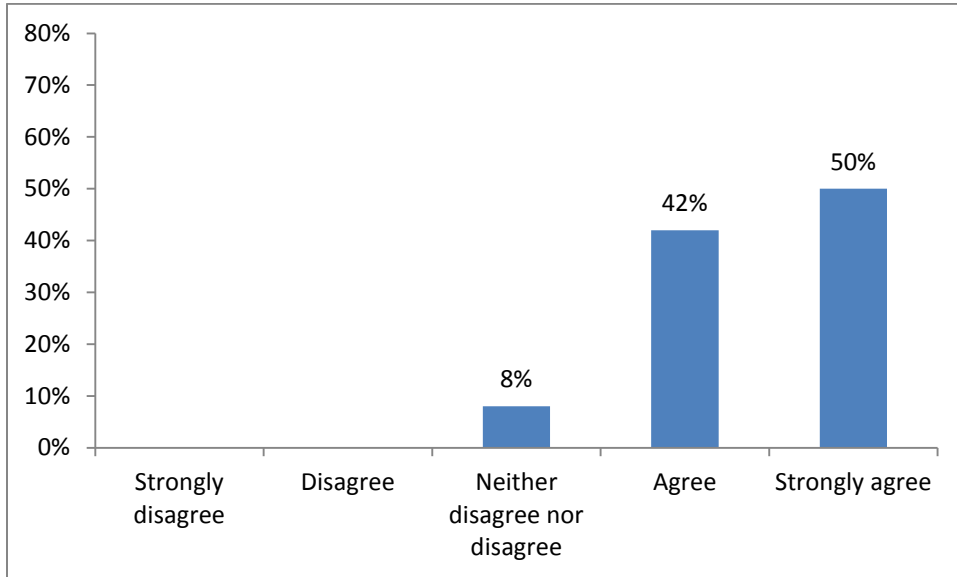


### Online, Post-Continuing Education Training Activity Assessments

Following each online continuing education activity, participants were asked to assess how much knowledge they gained (see Figure 75), and their perceptions of each activity’s training length (see Figure 76) and difficulty (see Figure 77). All the online trainings were aggregated together due to the small number of respondents who completed post-training assessments of the online training courses. Only thirteen individuals completed post-activity assessments for online training modules. Those training modules were: *Public Health 101: Definition and History of Public Health* (6 participants); *Public Health 101: Core Functions, Essential Services, and Ethical Practices* (3 participants); *Public Health 101: Introduction to Epidemiology* (3 participants); and *Public Health 101: Introduction to Biostatistics* (1 participant).

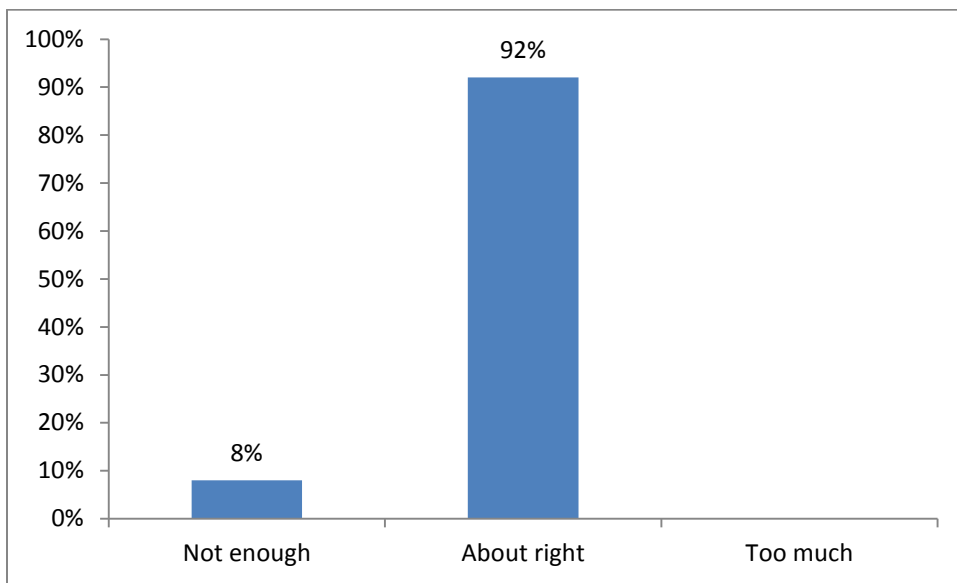
**Figure 75: Online, Post-Continuing Education Training Activity Assessments: Post-Event Knowledge Gain**

92% of respondents agreed or strongly agreed that their knowledge of the subject matter increased after participating in an online training module (n=12).



**Figure 76: Online, Post-Continuing Education Training Activity Assessments: Post-Event Perceptions of Training Length**

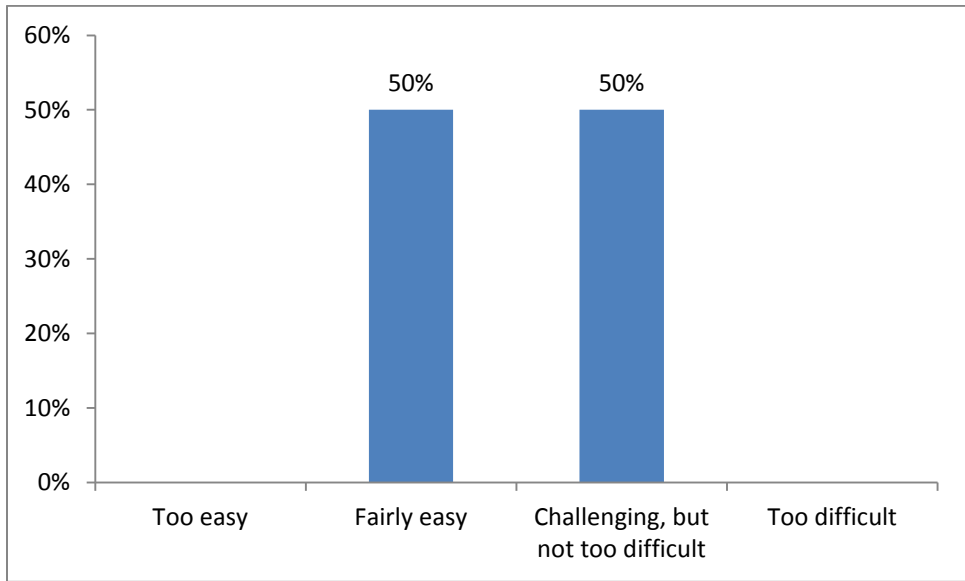
92% of respondents believed the length of the online training modules was about right (n=12).





**Figure 77: Online, Post-Continuing Education Training Activity Assessments: Post-Event Perceptions of Training Difficulty**

50% believed the online training modules were challenging, but not too difficult, and 50% of respondents believed they were fairly easy (n=12).



## CONCLUSION

In Year 2, the Great Plains Public Health Training Center expanded its activities significantly. It increased both the frequency and scope of continuing education activities, as well as added an online component to its available training resources. It maintained a statewide scope of experiential activities for students in both rural and urban communities. Participant satisfaction was high with both in-person and online training activities.

After one year, participants indicated that the Training Center’s continuing education activities had a positive impact in a variety of domains – personally, organizationally, and in the provision of services to the underserved and generally. This impact was reflected in a reported increase in one year public health competencies in 9 out of 10 competency domains. However, the increase was not statistically significant due to small sample sizes.



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