Public Health Workforce and Education Needs Assessment Report: Initial Data from Nebraska Public Health Stakeholders
This document affords a first look at an ongoing series of surveys and E-queries undertaken by the Nebraska Education Alliance for Public Health Impact (NEAPHI) to determine the training needs as well as outline the assets of the current system of Public Health in Nebraska. NEAPHI, a consortium of key public health organizations in Nebraska, (see 2003 Membership at left) is committed to working with Nebraska’s public health stakeholders to build public health capacity in Nebraska.

NEAPHI was established in the summer of 2000 when representatives of numerous academic and practice organizations concerned with Nebraska's public health workforce training and education came together to explore joint interests. A federation of interested organizations was formed, agreeing to meet quarterly in pursuit of strategies to address this common concern. NEAPHI's membership has grown to 31 organizations and has several projects currently underway. NEAPHI’s long-term objective is to build and sustain capacity in Nebraska to improve the public’s health. Currently, NEAPHI works to assess the current and future education and training needs of Nebraska’s public health workforce and to promote collaboration between academic and practice communities to address those needs statewide.

Over the course of three years, NEAPHI has undertaken an assessment of the needs and assets within Nebraska’s public health system related to leadership development, formal education and ongoing training and development. With funding received in 2002 from the Health Care Cash Fund Grant and in collaboration with the Nebraska Rural Health Association, NEAPHI is conducting a Statewide Summit on Public Health Education and Training to develop a three-year blueprint for action for public health education and training throughout Nebraska.

Part One of this summary offers the results of the Upper Midwest Public Health Training Center (UMPHTC) 2002 Public Health Training and Education Needs Assessment.

Part Two provides data from several sources: the Nebraska Local Health Department Survey, the Turning Point Stakeholders Survey, Rural Health Association Annual Conference Focus Group Data, Nebraska Association of Behavioral Health Organizations Survey Data, Community Action Agencies of Nebraska Survey Data and other public health conference and workshop evaluations.
Part One: The UMPHTC 2002 Public Health Training and Education Needs Assessment

**Background:** NEAPHI’s partnership with UMPHTC is crucial to the successful assessment and development of public health training and education. NEAPHI serves as Nebraska’s statewide advisory board within UMPHTC.

The purpose of UMPHTC is to provide a training center that will meet the public health training and education needs of Nebraska, Iowa, and South Dakota. UMPHTC is researching what is needed to build public health work force capacity and develop curriculum and methodologies that strengthen the competencies and capabilities of public health practitioners, students, and faculty. It is the goal of the UMPHTC to reduce unnecessary duplication of training and educational activities in Nebraska, Iowa, and South Dakota, and to make effective use of the training and education resources available.

To assess the current needs for public health training and education in Nebraska, The UMPHTC developed and delivered a needs assessment survey in April, 2002. Strategic assistance for survey development came from reviews of needs assessment surveys conducted previously by 14 Public Health Training Centers across the United States. The Nebraska survey subcommittee built upon the solid base of those previous surveys, assuring the questions best fit the status of public health in Nebraska. The final survey was then approved by the UMPHTC Tri-State Steering Committee. With the help of the NEAPHI Data Work Group, a variety of public health professions were selected to be surveyed. (See Appendix)

**Methods and Response:** The survey was mailed via U.S. Postal Service to a random sampling within each public health discipline identified. Respondents could mail back a completed paper copy of the survey, or access a website and enter their responses online. After the initial mailing, additional follow-up phone calls and mailed reminders were carried out in May and August. Survey recipients were able to return the survey through September, 2002.

The survey instrument was comprised of three sections designed to collect demographic information on respondents, to assess specific needs for training in core public health areas and to identify the best modality for meeting identified training needs. The first section adapted the “Ten Essential Public Health Services” to measure the level of need for training in specific areas using a four-point Likert scale (four meaning “high need” and one meaning “low need”). The second section of the survey, again using a Likert scale, measured the types, methods, and frequencies of a series of topical public health courses. The final section offered respondents the opportunity to provide individual demographic information.

In Nebraska, 989 surveys were mailed and 393 completed surveys were received, for a response rate of 40 percent. The following reports the detailed results of the survey response.

### I. Primary Worksite of Survey Respondents

The survey provided a list of 11 potential worksites, and respondents were asked to choose the one that best described their primary worksite. They were given the opportunity to write in an answer if their primary worksite was not listed. Those surveyed reflect a wide range of positions in public health. The highest number of responses by primary worksite came from the Nebraska State Health Department and from local public health departments, comprising approximately one-quarter (25 percent) and one-fifth (21 percent) of respondents, respectively. Academic institutions and hospitals tied for the third largest number of respondents (15 percent each). Few of the community health workers responded.
II. Geographic areas where respondents work
Respondents selected from seven categories to define the geographic area in which they work. Respondents primarily worked in urban areas (45 percent), defined as 50,000 population or larger, followed next by rural areas (23 percent). Other categories respondents chose from included: frontier (one percent), suburban (two percent), native community/reservation (four percent), city/town 25,000 or larger (11 percent), and small city/town under 25,000 (14 percent).

III. Current position of survey respondents
Respondents described their current position by selecting from nine choices: public health director, physician, board of health member, dietician/nutritionist, environmental health specialist/sanitarian, health educator, hospital administrator, nurse, and “other.” Nurses comprised the largest group of responses (26 percent). Environmental health specialists/sanitarians and health educators provided the second-largest response at 15 percent each. Hospital administrators provided the next highest level of response with 10 percent.

IV. Training needed in activities to promote the ‘Ten Essential Public Health Services’
Questions asked were based on the “Ten Essential Public Health Services.” Each essential service was listed, immediately followed by two statements pertaining directly to performing the activities of that service. The participant was asked to rate the need for training as it related to being able to perform each activity listed, using a scale of one through four, with one being the lowest need for training and four being the highest need. The service for which respondents felt the most need for training was: “Inform, educate, and empower people about health issues,” with a mean rating of 2.64 on the four-point scale. The second-highest ranked training need was for the service “Enforce laws and regulations that protect health and ensure safety,” with a mean of 2.6.
UMPHTC Public Health Training and Education Needs Assessment
Nebraska
n=392

Activity
Rate your own level of need for training in this area. (1 = Low Need, 4 = High Need)

A. Monitor health status to identify community health problems

1. Identifying and acquiring meaningful data to determine the significant health issues in your community.

   Mean, 2.61

2. Analyzing, interpreting and presenting data on any significant health issues in your community for specific groups.

   Mean, 2.56

B. Diagnose and investigate health problems and health hazards in the community

3. Researching data findings to understand and identify the risk factors for a health problem in your community

   Mean, 2.43

4. Understanding investigation techniques and demonstrating the ability to investigate the significant risk factors in your community.

   Mean, 2.5

C. Inform, educate, and empower people about health issues.

6. Developing educational programs for providers, agencies and the general public in your community that cover material on health issues or problems in your community.

   Mean, 2.68

   Mean, 2.57

D. Mobilize community partnerships and action to solve health problems

8. Developing strategies and plans in your community to carry out programs related to your community's health issues and problems through convening and facilitating community groups.

   Mean, 2.38

   Mean, 2.45

5
E. Develop polices and plans that support individual and community health efforts

10. Understanding and developing processes to change policies and protocols in your community as needed.

F. Enforce laws and regulations that protect health and ensure safety

12. Understanding the rights of individuals within the public health laws and regulations.

G. Link people to needed personal services and assure the provision of healthcare when otherwise unavailable

14. Adapting health service programs to take into account differences in the population (e.g., need for translators, transportation, and gap filling).

H. Assure a competent public health and personal health care workforce

16. Ensuring that the public health workforce in your community have the competencies needed to carry out their jobs. This includes knowledge, skills, resources, access to training, and current licenses and credentials to provide needed programs, support
I. Evaluate effectiveness, accessibility, and quality of health services

17. Conducting surveys and studies to measure the timeliness, appropriateness, and effectiveness of population based health care services in your community.

Mean = 2.25

18. Analyzing results to determine the timeliness, appropriateness, and effectiveness of population based health care services in your community.

Mean = 2.25

19. Utilizing results for application in performance measurement reporting to determine the effectiveness of public health population based programs.

Mean = 2.36

J. Research for new insights and innovative solutions to health problems

20. Identifying best practices for programs/services at the local, state or national level regarding health policies.

Mean = 2.54

21. Creating new and strengthening existing partnerships between public and private organizations to deliver public health services (population based focus).

Mean = 2.59

V. Participation in public health training and education opportunities

In separate questions, participants were asked to rate on a scale of one to three, with one being “not at all likely” and three being “very likely” the training and education courses in which they would be most likely to participate. Most participants chose “leadership” (mean rating of 2.26 on a three-point scale) followed by cultural competence (mean = 2.22) as the courses in which they would most like to participate. Respondents rated continuing education courses that provide professional continuing education (CE) credits (but do not lead to a degree or certificate), as the most preferable mode to receive education (mean = 2.24).

How likely are you to participate in a training program (series of courses) in one of the following areas?

1. Leadership
Mean = 2.26

2. Cultural Competence
Mean = 2.22

3. General Public Health
Mean = 2.17

4. Management
Mean = 2.12

5. Preparedness
Mean = 2.08
How likely are you to participate in one of the following?

1. Continuing education courses that provide professional continuing education (CE) credits but do not lead to a degree or certificate.
2. A Certificate Program in Public Health from an academic institution in one of the areas listed in questions 22-26. (Certificate Program: four courses, 12 academic hours via distance learning modalities.)
3. Courses that can be applied toward a graduate degree.
4. Courses that can be applied toward an undergraduate degree.

VI. Barriers to receiving public health training and education
Participants rated six options according to their perception of that factor as a barrier to participating in a public health training program, on a scale of one to four, with one meaning “not at all a barrier” and four meaning “very much a barrier.” The highest ranked barrier was that of financial resources (mean = 2.46), followed closely by “having to take vacation time to complete a course” (mean = 2.43). “Lack of employer support” was least likely to be a barrier to completing an education or training course (mean = 1.93).

How much are the following factors likely to be barriers to your participating and completing a public health training program?

1. Continuing education courses that provide professional continuing education (CE) credits but do not lead to a degree or certificate.
2. A Certificate Program in Public Health from an academic institution in one of the areas listed in questions 22-26. (Certificate Program: four courses, 12 academic hours via distance learning modalities.)
3. Courses that can be applied toward a graduate degree.
4. Courses that can be applied toward an undergraduate degree.

VII. Technology as a means of training and education
Participants were asked what type of technology they had access to at work and at home. Ninety percent of respondents said that they have access to a computer, software, and an internet browser at the workplace. Approximately 70 percent of respondents had the capability to download specific software, a telephone line modem, and an internet account at work. Fifty percent of respondents have DSL or cable modem connection at their workplace.

Similar numbers were reflected in the technology available in the homes of survey participants. Over 70 percent had an internet account, DSL or cable modem, software, a telephone line modem, and/or a computer available to them.
Summary by current position (top three positions surveyed in NE, IA, and SD)
Rate importance of skill to job: Both Nurses \((n=494)\) and physicians \((n=128)\) rated highest the ability to link people to needed personal services. Second highest was enforcing laws and regulations, followed closely by the ability to inform, educate, and empower. Environmental Health staff \((n=132)\) saw enforcing laws and regulations and developing policies and plans as the two most important skills to their job, followed by the ability to inform, educate, and empower.

Methods for receiving training: Interesting differences arose in the responses to preferred methods for receiving training. Nurses preferred on-site training, internet based training and videotapes. Environmental Health staff most preferred on-site, internet-based training, followed by the equally ranked CD ROM and a two-day course taught during the work week. Physician preference was to receive training via the Internet, CD ROM and videotape.

Summary by geographic location (top three positions surveyed in NE, IA, and SD)
Rate importance of skill to job: Respondents from Urban or Central City areas \((n=608)\) felt the most important skill was linking people to needed personal services. This was followed by the ability to enforce law and regulation, and by the ability to inform, educate, and empower. Respondents from both the more rural areas \((n=525)\) and small city/towns ranked the ability to enforce law and regulation as most important, followed by linking people to needed personal services. Those responding from rural areas ranked monitoring health status third and those from Small city/town areas ranked the ability to inform, educate and empower third.

Methods for receiving training: Respondents from both the Urban/Central City areas and the rural areas ranked their preferences for training methodologies as on-site, followed by Internet and videotapes. Those from Small cities/towns preferred the same three but in the order of on-site, videotape and Internet.
Part Two:

A. Nebraska Local Health Department Survey Data: The 2001 Nebraska legislative session saw the passage of LB 692, the Nebraska Health Care Funding Act. The bill used money from Nebraska’s tobacco settlement to allow the State’s communities to identify and meet local health care needs. With funding from this bill, Nebraska added 16 new public health departments within six months, which serve 84 of 93 counties. One year prior to the passage of LB 692, only 22 Nebraska counties were served by local health departments. Local health departments can assess the health needs in their community, develop policies to address health needs, and assure that needed public health services are available and accessible to their community.

In July of 2003, a four-question, one-page, anonymous-response, written survey designed by the Statewide Summit Task Force, was sent out to 17 local health departments with a self-addressed stamped envelope. The survey asked about the public health education and training needs of the health department. A cover letter explaining the critical need for this data and assuring the anonymity of responses accompanied each survey. 16 surveys were received; one survey was returned undeliverable; nine surveys were completed and returned.

Respondents were asked to rank the top five priority training and education needs in their organization. The top responses, including ties were: epidemiology, dealing with difficult customers/customer service training, emergency response/bioterrorism planning, management, exercises, Time management, professional/academic public health training/education, e.g., theories, core functions, principles, etc., HIPAA/continuing ed for legal changes, computer training, health board roles and responsibilities/strategic planning, and managing employees.

Respondents to this question also offered a large number of additional training and education needs, including but not limited to: board training in public health, government/non-profit accounting, bioterrorism training for volunteers, investigating complaints against employees, oracle training (accounting system), asset mapping, GIS, budget development, grant writing and management and program evaluation.

When asked what the preferred methods for necessary training to satisfy education and training needs within their organization were, the highest ranking responses were: incorporating ties as video conferencing, internet, conference calls, face-to-face speakers/training, CD ROM, classroom instruction, and training outside of the office. Additional methods mentioned were: seminars, educational video tapes, conferences, and on-site training.

Respondents were asked about their awareness of assets and opportunities available to help public health workers receive education in their area or organization. The top five responses to this question were: NECC-Lifelong Learning Center, Wayne State College and professors, ESU-3, Leadership Quest Course, EDGE course, Good Samaritan Health systems video conferencing capabilities, UNMC. Others mentioned included the Public Health Association of Nebraska (PHAN), The National Association of City and County Health Officials (NACCHO), Columbus Community Hospital, Central Community College and several more.

Last, respondents were asked about their perceptions of barriers to obtaining needed training and education for their organization. The top responses were time, distance/travel time, cost of meetings and travel, time out of office/nobody to fill one’s position when gone, and availability. Also mentioned were the time of year, the unique needs of every health department and the availability of training offerings in CEU’s.
B: Turning Point Stakeholders Survey

A grant received from the Robert Wood Johnson Foundation called, “Turning Point,” made it possible to develop a strategic plan for public health in Nebraska. The plan was developed by the Nebraska Community Health Partners Stakeholders Group (NCHPSG). Formed in 1997, the group represents many different organizations including: Public Health Association of Nebraska, Nebraska Association of Farmworkers, The Environmental Health Association, Nebraska Nurses Association, the Nebraska Minority Public Health Association, the Nebraska Hospital Association, the Nebraska Medical Association, Community Action Agencies of Nebraska, local health departments, medical centers, employers, private insurance, the faith community, county officials, the State Legislature, and Nebraska Health and Human Services.

The NCHPSG is primarily responsible for implementing the strategic plan for public health. Regular meetings are held to plan for public health infrastructure, and to consider the needs of newly-formed local health departments, public health policy, specific training needs, and other issues in building public health. At the Turning Point NCHPSG August, 2003 meeting members in attendance were queried for verbal feedback on four public health education and training needs survey questions formulated by the task force. Their responses follow:

When asked what the priority training and education needs in their organization might be, respondents said that many local health departments are new and are in the process of trying to get the office up and running. These new health departments need training in strategic planning and organizational management for local health departments. New local health departments also need training in data management/analysis and use, and for new Local Boards of Health about their responsibilities and operation. Health departments are asking for health education and promotion training to assist them with developing programs in the local health department. Health directors need an understanding of basic public health law, and about annual reporting to the State Health Department. Directors want to know what the report should look like and what information it should contain. Training is needed on health public relations, marketing, and cultivating community involvement. Additionally, a printed form of all public health acronyms would be useful.

The members’ preferred methods for meeting education and training needs were Telehealth/video conferencing, congregating at remote sites to allow face-to-face training/education, and receiving training via Internet, both live and archived.

Assets and opportunities that might help public health workers receive continuing education of which members were aware in their respective communities or organizations comprised the Nebraska Nurses Association newsletter Nebraska Nurse published four times per year and containing self-study continuing education units, the Public Health 101 video series produced by the UMPHTC, that consists of experts in state in different areas of public health giving eight one-hour segments of training, and the PHAN website’s section on social marketing, consisting of six health topic PowerPoint presentations.

Members responding perceived educating state and local elected officials about public health continued training needs due to turnover, motivation and time to be the barriers to meeting training and education needs.

C. Rural Health Association Annual Conference Focus Group Data

The Nebraska Rural Health Association is a non-profit, project-oriented membership organization whose primary mission is to work for the preservation and improvement of health care for rural Nebraskans. The Nebraska Rural Health Association provides a forum for the exchange of ideas and the resolution of problems faced by rural consumers and health care providers such as identifying key legislative issues affecting rural health care and assessing health disparities in rural areas.

The “Public Health Workforce Focus Group” was held at the 2003 Annual Rural Health Conference in September, 2003, to gather input from rural health workers about their public health educational and training needs. Approximately 10
people attended the focus group, including people from a wide-range of public health fields such as local health departments, Nebraska Health and Human Services, Adult Day Care Association, and the Area Health Education Center. A facilitator asked the group a series of questions. The group’s responses follow.

The group echoed responses from other groups surveyed by responding they need to know where to go for information, need training in basic epidemiology, cultural competency, and the public health planning process. They also mentioned many of the same barriers to receiving needed training, e.g., time, being unable to have more than one person at a time out of the office for training, and costs. Responses unique to this survey included the need for more maternal and child health training and education on aging issues.

Focus group participants listed the top priority training and education needs in their organization as skills for dispensing medications according to state regulations, information about health issues, diseases, e.g. tobacco, cessation, health education information, knowing where to go for information sources, basic skill building/orientation in public health principles and concepts for people without formal public health training, maternal and child health skills/knowledge, education on aging issues, basic epidemiology skills i.e. training on a variety of levels such as degree, certificate, or workshops. They also ranked getting tools and skills-building in the public health planning process including assessment, assets, priority setting, implementation and evaluation. Participants also mentioned additional training for volunteers and for Boards of Health and for cultural competency according to varied levels of need.

Preferred methods for receiving necessary training to satisfy education and training needs within their organizations included: basic technical assistance for elderly employees, opportunities for nurses to get advanced degree by helping to overcome barriers, comprehensive staff development plan including tuition assistance, encouragement, incentives, employer policy/practice, access to advanced degree/education without going to Lincoln or Omaha, more gerontology and maternal and child health in rural areas, strategic planning goals, grant management and budgeting, and tools and techniques for needs assessments.

Assets and opportunities that might help public health workers receive education in their area or organization which participants were aware of included: library equipment, information; experts in practice and academia, CDC downlinks, PHAN website, technology at public schools and community colleges, Mini-Med School at UNMC twice per year, Public Health 101 videos and CDs, MA and MPH classes and degrees, family, community, leadership training at extension, partnering with other states in specific areas, e.g. maternal and child health, and the Adult Day Care Association including program assistant training and self-help training.

Possible barriers to meeting the training and education needs of members of their organizations included costs, language/translated materials, lack of compensation to recognize trained public health professionals, technical difficulties, lack of awareness of events, family obligations/time, lack of travel time, no access to the Internet, the difficulty involved in releasing more than one person to attend at a time, and downlinks not being opened up across “sectors.”

### D. Nebraska Association of Behavioral Health Organizations

Behavioral health fulfills a defined purpose within the context of public health in the delivery of mental health and substance abuse services. The mission of the Nebraska Association of Behavioral Health Organizations (NABHO) is to “promote sound, responsive, efficient, and effective
substance abuse and mental health services for the people of Nebraska.” NABHO members are community behavioral health organizations who serve over 29,000 Nebraskans.

A survey of public health education and training needs was distributed to community behavioral health organizations from across Nebraska at the NABHO Board meeting in September, 2003. 15 completed surveys were returned by September 2003. The participants were only asked to list their responses, not necessarily rank them according to priority. Description of training and education needs differed from other organizations surveyed in that many of the needs cited by NABHO members were specifically related to the delivery of mental health and substance abuse services. The most frequently mentioned training needs were: crisis intervention, sex offender evaluation, dual-diagnosis training, and training for psychiatric technicians.

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Other needs mentioned more than once, and corresponding with needs mentioned by other surveyed groups included cultural competency and technology training to increase organizational efficiency. The three most preferred methods for receiving the needed training were listed as videoconferencing, in-person and on-site training, and CD ROM. In response to asking what opportunities were available in the area of the organization that helped staff members to receive training, several respondents mentioned the telehealth capabilities at BryanLGH medical center in Lincoln, Nebraska, community colleges, and University of Nebraska Medical Center continuing education programs.

Respondents stated their largest barriers to receiving the training they needed were time, costs/small training budget, and the demands of large case loads.

F. Community Action Agencies of Nebraska

Community action agencies play an important part of public health delivery. The purpose of community action agencies are community building, human services delivery, and low-income advocacy. Due to this purpose, community action agencies are especially helpful in promoting access to care for many underserved populations in our communities. There are currently nine community action agencies in Nebraska. Community Action of Nebraska, Inc. is a nonprofit corporation that coordinates communication between the state Community Services Block Grant administrator and the community action agencies of Nebraska, provides training and programs to community action agencies, and performs other duties to strengthen community action in Nebraska.

A survey of public health education and training needs was distributed to 36 Community Action Agencies from across Nebraska at the Community Action of Nebraska, Inc. Board meeting in July, 2003. Six completed surveys were returned by September, 2003. The participants were only asked to list their responses, not necessarily rank them according to priority.

In responses to the first question, Board members listed five priorities for training and education needs in their organizations. Response included determining when to refer for mental health services, accessing dental services for children, accessing mental health services, grantwriting, resource development, marketing, maintaining community coalitions, understanding legislative processes, increasing knowledge of public health issues, raising awareness of multi-cultural issues, interpreter training, technology training, and case management.

When asked to list preferred training methods to satisfy education and training needs, respondents listed Internet, CD ROM, videoconference, one-on-one, in-person, on-line forum, local workshops, and professional trainers.
Local or organizational assets and opportunities for education and training included the health department, Southeast Community College, videoconference links/facilities, in-house PowerPoint presentations, collaborations with nearby public health departments, receiving notices of upcoming trainings when available, hospitals, Buffalo County Community Health Partners, and Alegent NPG Health Link.

The Board respondents perceived time, training costs (travel)—limitations on what is an allowable cost, and needed training either not available in the area or at a specific time as barriers to meet the training and education needs for their organizations.

E. Other Public Health Conference and Workshop Evaluations

Evaluations were distributed at the following conferences and workshops: PHAN Annual Conference, September 2002; Nebraska Rural Health Association 2002 Annual Conference; Public Health Workforce Training Workshops on Strategic Planning in April 2002; Grantwriting, in February, 2002; Communications in April, 2002; and Resources in April, 2003. Participants were asked what topics should be addressed at future conferences/workshops and were not asked to rank/prioritize their suggestions. Responses were analyzed for repeated suggested and several key themes about public health training needs in the field emerged from an aggregate of the data. Training for assessment, specifically the processes and methods for performing specific public health needs assessments and how to write a needs assessment, were identified. Education for new Boards of Health and other aspects related to Boards of Health, as well as ways to use data more effectively were cited. Training on the role of emergency systems in public health delivery and on bioterrorism, were high on the list of identified needs. Using epidemiology and biostatistics, as well as finance issues, use of GIS, issues related to securing and sustaining grant funding and other resource issues were high need areas. Education on all aspects of strategic planning and issues of identification of, access to and service for underserved and minority populations rounded out the list.

Summary:

Public health organizations have a large breadth of activities to perform with regard to health education, assessment, access to health care services, outreach, and policy development. However, public health organizations generally have limited financial and human resources, making it very difficult for public health workers to receive education and training in these diverse areas in order to help them perform these duties. In order to reflect the varied composition of the public health field, a variety of organizations and public health professionals were surveyed. Though the respondents have very different professions within public health, most respondents mentioned very similar training and education needs and almost identical barriers to meeting these needs. Equally interesting is that nearly all of those who completed a survey mentioned a different resource they used to help meet their organization’s training and educational needs. Therefore, a large and varied amount of resources exist to meet a limited number of education and training needs—a realization that makes the job of matching existing resources to needs seem quite feasible.

Initial data from surveys and focus groups of Nebraska public health stakeholders clearly supports these ideas. The findings illustrate common training and educational needs and the barriers to fulfilling these needs across different sectors of Nebraska’s public health workforce. For example, all groups they had an identified need for education or training in four or more of the following areas: epidemiology, cultural competency, emergency response, organizational management, data use, and training local Boards of Health. In addition, every surveyed group mentioned time, costs, and difficulty in taking time off work as the top barriers to taking advantage of opportunities to meet their training and education needs.

There are several caveats to interpreting the collected data. Numerous organizations will have held annual meetings (where the survey is often administered or a focus group is held) after this document has been printed, precluding their information from inclusion in this document. The information derived from such surveys is forthcoming and equally important to consider when analyzing existing needs, barriers, and resources. The second caveat found in data interpretation refers to information provided by the members of the Nebraska Association of Behavioral Health Organizations (NABHO). NABHO members cited training needs that were specific to mental health such as crisis intervention, sex offender evaluation, and psychiatric technician training. However, NABHO respondents offered the same preferred methods for receiving training and the same barriers to receiving training as the other groups surveyed.
In order to find initial resources to meet educational and training needs, technological resources were researched and academic institutions that potentially offered training and educational opportunities were surveyed. A substantial amount of resources were found to exist that directly address many of the needs mentioned. Such resources include: distance education at most community and state college campuses, and at the University of Nebraska campuses, continuing education units, and CD ROM and video public health training sessions. With this initial compilation of needs and resources compiled, a measure of responsibility lies with Nebraska’s public health stakeholders and the owners of the resources to commit to coordinate and cooperate to appropriately fulfill each organization’s training or education needs. To that end, the foundation has been laid for the second step in the process of training and educating Nebraska’s public health workforce: development of a written blueprint for public health training to guide the training and education process for public health workers across Nebraska. This training guide will afford Nebraskans the more refined delivery of public health services and, thereby, a healthier Nebraska.


1 <http://www.public-health.uiowa.edu/UMPHTC/>
Appendix