SOUTH CENTRAL PUBLIC HEALTH PARTNERSHIP

OVERALL PROGRAM EVALUATION -- 2010-2011

- South Central Public Health Leadership Institute (SCPHLI)
- South Central Public Health Training Center (SCPHTC)
- South Central Preparedness and Emergency Response Learning Center (SCPERLC)

SHEILA W. CHAUVIN, PH. D., M. ED.
Evaluation Consultant

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INTRODUCTION

The South Central Public Health Partnership (SCPHP) was first established as an advisory committee for the South Central Public Health Leadership Institute (SCPHLI) when this program was first implemented in 1995, with funding support from the Centers for Diseases Control (CDC). The SCPHLI advisory committee included representatives of state departments of public health leadership and other key stakeholders from Arkansas, Alabama, Louisiana, and Mississippi. In subsequent years, as the South Central Public Health Training Center (SCPHTC) was created with support from the Health Resources and Services Administration (HRSA) in 2000 and the South Central Center for Public Health Preparedness was established in 2002 with funding from the CDC. The SCCPHP was replaced in 2010 by the South Central Preparedness and Emergency Response Learning Center (SCPERLC) that continues the training focus, also with funding from the CDC. Thus, the SCPHP's three centers (SCPHLI, SCPHTC, and SCCPHP/SCPERLC) have enjoyed continuous funding from its federal sponsors and the SCPHLI has also been supported continuously since its early start with additional funding support from the participating state departments of public health. Since the early formation in 1995, the advisory committee has formalized and expanded to reflect a regional partnership for which a substantial Advisory Board has existed. The Arkansas Department of Health withdrew from the partnership in 2009 and the remaining partners from Alabama, Louisiana, and Mississippi continue to be actively engaged in the SCPHP.

Since the beginning of the SCPHP, an overall evaluation of the SCPHP effectiveness has been conducted each year. In particular, the evaluation has targeted consistently the extent to which SCPHP and its training centers have demonstrated the following: 1) mission-based training and workforce development support; 2) effective academic-center-practice partner interactions; and 3) value-added training and workforce development resources and expertise. While each annual evaluation has targeted these broad purposes, the specific evaluation focus and process has been decided annually with input of the academic and practice partners. Shared ownership for evaluation and flexibility to meet particular needs have contributed substantially to the ongoing and active use of the evaluation results for both formative and summative purposes. That is, results are routinely reported to and used by the Advisory Board to identify and respond appropriately to training and partnership needs and opportunities for development and improvement.

EVALUATION FOCUS FOR 2010-2011

The evaluation focus for 2010-2011 was two-fold. First, a comprehensive and multi-dimensional training needs assessment (TNA) was conducted, based on the following data sources: 1) analysis of multiple TNAs completed since 2005, 2) examination of evolving changes in core public health and preparedness and response competencies, 3) systematic review of all web-based curriculum and courses developed and delivered by the SCPHTC and the SCCHP/SCPERLC, and 4) direct input from practice partner representatives. Results of the TNA were submitted to the SCPHP Advisory Board Executive Committee in May 2011 and discussed and used at its June 2011 meeting to plan for the 2011-2012 project period of its Centers. A complete description of the TNA study and its results and recommendations is available in a separate report. The second focus of the 2010-2011 overall evaluation was on practice partner perceptions of the SCPHP, particularly in terms of specific elements of each training center/institute and the value or impact of these training and workforce development contributions.

METHODS

Practice partners of the SCPHP Advisory Board comprised the sample (n=34), as these individuals are the most knowledgeable about the partnership interactions and the contributions of the centers to workforce development in their respective agencies. A questionnaire was designed to solicit input and reflected an updated version of one used in 2009.

Participants provided the state and agency they represented, but did not include their name on the questionnaire. Both quantitative and qualitative data were gathered. The questionnaire consisted of three parts. Part I included six or seven items for each center/institute and provided participants a four-point Likert scale (1=strong disagree, 2=disagree, 3=agree, 4=strongly agree), to indicate the extent to which the particular center/institute reflected the quality represented in the item statement (e.g., is a significant resource, provides expertise, enhances staff knowledge and skills, enhances actual performance). Part II included 9 items reflecting various training resources and formats to which participants were asked to indicate the extent to which each represented a critical workforce development need or type of resource for their organization. For these items, participants used a four-point Likert-type response scale (1=definitely not critical, 2=not critical, 3=critical, 4=definitely critical). Part II also included two open-ended questions (other critical or emerging needs, suggestions for improvements) to which they provided narrative responses. Finally, Part III solicited narrative responses that described *critical incidents or stories of impact* that demonstrated how the SCPHP and/or any center/institute had added value or made a significant difference to workforce development in practice partner agencies.

The questionnaire was administered to the 34 SCPHP Advisory Board practice partners in July 2011 as an attachment to an email message. The message included directions and assurance of voluntary and confidential participation. Email reminders were used to achieve the maximum possible response rate. Participants returned their completed questionnaire as an email attachment. Upon receipt, questionnaires were separated from the email messages that were subsequently

deleted. The dataset used for analysis did not include any individually identifiable information.

Quantitative data analysis included calculation of summary descriptive statistics for total respondent group and by state sub-group. Qualitative analysis of narrative responses to the two open-ended questions and for descriptions of critical events and stories of impact reflected thematic content analysis for any common perspectives.

RESULTS

Two rounds of email reminders were used to enhance the final response rate. Of the 34 participants, undeliverable notices were received for two, and useable data were obtained for 11 of remaining 32 participants (34.38% response rate) and distributed by state as follows: Alabama = 4, Louisiana = 4, and Mississippi = 3. While the response rate was lower than desired, the respondents, as a group, were well-informed members of the SCPHP Advisory Board, both in terms of active participation and knowledge regarding how their respective agencies actually used and benefitted from the partnership and its centers' resources and course offerings.

QUANTITATIVE RESULTS

Tables 1-3 show mean ratings for the total group and by state that were mostly 3.00 or higher for each center. Table 4 shows mean ratings mostly around 3.00 for items pertaining to training resources and formats. Standard deviations were calculated and included in Tables 1-4 for total group responses, but not for state level results, since the number was so small for each group.

Tables begin on the next page.

Table 1. Summary descriptive statistics for South Central Preparedness and Emergency Response Learning Center (SCPERLC) for items (total group) and for total scale (total group and by state).

To what extent do you agree that the SCPERLC (preparedness/emergency response):	**M[a]**	**sd**
1. is a significant resource for workforce development regarding emergency and disaster preparedness and response.	3.09	0.30
2. provides expertise that would otherwise not be available.	3.18	0.60
3. provides responsive technical assistance that would otherwise not be available.	3.00	0.63
4. has enhanced staff knowledge and skills in emergency and disaster preparedness and response.	3.18	0.60
5. has enhanced actual performance in emergency/disaster situations (i.e., simulated or real).	3.27	0.47
6. has had a positive impact on your organization's emergency/disaster response.	3.18	0.40
Total scale means:		
All states	3.15	
Alabama	2.88	
Louisiana	3.21	
Mississippi	3.44	

[a]M = mean, sd = standard deviation, Response scale: 1 = strongly disagree, 2 = disagree, 3 = agree, 4=strongly agree

Table 2. Summary descriptive statistics for South Central Public Health Training Center (SCPHTC) for items (total group) and for total scale (total group and by state).

To what extent do you agree that the SCPHTC (training center – core public health):	**M[a]**	**sd**
1. Is a significant resource for workforce development in core public health competencies.	3.18	0.40
2. provides expertise that would otherwise not be available.	3.27	0.47
3. provides responsive technical assistance that would otherwise not be available.	2.91	0.70
4. has enhanced staff knowledge and skills for public health practice.	3.30	0.48
5. has enhanced actual job performance of public health staff.	3.10	0.57
6. has had a positive impact on your organization's responsibilities for public health.	3.18	0.40
Total scale means:		
All states	3.16	
Alabama	2.90	
Louisiana	3.20	
Mississippi	3.44	

[a]M = mean, sd = standard deviation, Response scale: 1 = strongly disagree, 2 = disagree, 3 = agree, 4=strongly agree

Table 3. Summary descriptive statistics for South Central Public Health Leadership Institute (SCPHLI) for items (total group) and for total scale (total group and by state).

To what extent do you agree that the SCPHLI (leadership institute):	**M[a]**	**sd**
1. Is a significant resource for leadership development.	3.55	0.52
2. provides expertise that would otherwise not be available.	3.55	0.52
3. has enhanced participants' knowledge and skills in leadership.	3.36	0.50
4. has enhanced leadership performance in your organization.	3.36	0.50
5. Is an essential component of leadership succession in your organization.	3.36	0.50
Total scale means:		
All states	3.44	
Alabama	3.00	
Louisiana	3.60	
Mississippi	3.80	

[a]M = mean, sd = standard deviation, Response scale: 1 = strongly disagree, 2 = disagree, 3 = agree, 4=strongly agree

Table 4. Summary descriptive statistics for workforce development resources and formats for items for total group and state.

To what extent does each of the following types of SCPERLC/SCPHTC/SCPHLI services and formats represent a critical need or resource for your organization:	Total Group		State Means		
	M[a]	sd	AL	LA	MS
1 Web-based courses	3.27	0.90	3.00	3.00	3.33
2 Webinars/Satellite seminars	3.18	0.87	2.75	3.25	3.67
3 In-person training activities (e.g., workshops)	3.36	0.67	2.75	3.00	3.33
4 Regional conferences	2.91	0.70	2.75	3.50	3.33
5 In-person train-the-trainer programs	3.09	0.54	3.00	3.50	3.33
6 Certificate programs (i.e., series of web-based courses)	2.91	0.70	3.00	3.00	3.67
7 Technical assistance for developing training programs and drills	2.91	3.00	3.00	3.25	3.33
8 Technical assistance for developing and using assessment tools and procedures	3.00	0.47	3.00	3.25	3.67
9 Internship program	3.00	1.10	2.75	3.00	3.00

[a]M = mean, sd= standard deviation, Response scale: 1 = definitely not critical, 2 = not critical, 3 = critical, 4 = definitely critical

QUALITATIVE RESULTS

The first open-ended question solicited input regarding critical or emerging training needs. The second open-ended question asked participants to describe any areas in which the SCPHP can improve and to include specific suggestions.

Training Needs: Input was received from four respondents and the remaining seven did respond at all to this item. Of the four responses, all three state practice partner agencies were represented. While the number of narrative responses was quite small, there was a clear need across the states for helping staff, particularly supervisors and managers, learn how to develop, implement, and evaluation specific and systematic approaches for training/education plans (individuals and targeted groups/staff categories). Given the brevity of available responses, each of the verbatim responses is shown in the Table 5 below. Specific words and phrases are underlined to demonstrate the recurrent theme across responses that pertained to *methods for designing, and facilitating effective use of systematic training/education plans*.

Table 5. Verbatim item responses pertaining to critical or emerging needs or opportunities for future planning by the SCPHP with key words and phrases underlined.

#	Verbatim Response
1.	In today's changing workforce, I think there needs to be a clear understanding of the importance of succession planning.
2.	Public health accreditation and performance improvement
3.	Assistance with exercise development and execution; assistance with plans development
4.	Training or education plans tailored to groups of public health professionals (food safety inspectors, wastewater specialists, etc.) or to an individual in public health that would include a number of classes that could lead employees through specific training/education to make them minimally qualified, fully qualified, and proficient at their work. Further, as staff is being prepared to take supervisory or management responsibilities above their technical knowledge, that they enter into and complete supervisory or management training with the culmination being SCPHLI. What does good look like? All public health employees have a training plan that includes coursework to help them be successful in their positions and that the plan is updated annually along with supervisory training to help make the process successful. Colleges and technical schools facilitate similar processes to help guide students in their field of study to gain the necessary knowledge and/or skills to be minimally qualified, fully qualified or proficient in the skills necessary for them to be successful. We have a wealth of resources available in these three centers. These training plans may help increase the utilization of these resources while helping better prepare the public health workforce.

Improvements: Four respondents provided input, of which one indicated that improvement s were "not applicable." The verbatim responses shown in Table 6 reinforce state practice partners' focus on training/education plans and maximizing the courses and opportunities available from the SCPHP Centers. Again, key words and phrases have been underlined to demonstrate the supporting evidence.

Table 6. Verbatim item responses pertaining to critical or emerging needs or opportunities for future planning by the SCPHP with key words and phrases underlined.

#	Verbatim Response
1.	NA
2.	Increased communication regarding opportunities that exist – enhanced emails/listserv
3.	Increase training for plans/development
4.	As training plans are developed there will be needs for additional courses, seminars, etc. Gauge interest in leveraging LMS to allow local and state public health agencies to track all SCPHP, other federal and state classes in one system.

The final part of the questionnaire asked participants to describe *critical incidents* or *stories of impact*. Such incidents/stories were defined for participants as *rich, meaningful examples that stand out in your memory and demonstrate vividly how the SCPH Partnership and its Centers/Institute have added value or made a significant difference in workforce development in partner agencies*.

Five of the 11 respondents described one or more of the nine incidents/stories obtained. While there is some overlap across centers and the overall partnership in these incidents/stories, each one emphasized at least one element that added value or made a significant difference in public health workforce development. Of the nine, one targeted the SCPHP, as a whole; four reflected aspects of the SCCPHP/SCPERLC, of which one also included core public health training (SCPHTC); and four reflected impact of the SCPHLI. The small number of incidents/stories obtained allow for inclusion of all of them in this report, rather than a representative sampling. The verbatim descriptions, excluding any personally identifiable content, are provided in the remainder of this section. The incidents/stories include explicit examples and perspectives representing all three statewide public health practice partner agencies and one of its city-wide agency partners. The source of each incident/story is included.

SCPHP (PARTNERSHIP, AS A WHOLE):

- In general the Partnership, et al. has provided excellent training opportunities for emergency response and public health workers throughout the region. The Partnership fosters communications among multiple states and multiple agencies, and allows for much needed networking. The lessons learned from actual disasters are invaluable in improving emergency, public health, and all agencies' responses during any future disaster. (*Mississippi Department of Health*)

SCCPHP/SCPERLC

- Interns from various cohorts at Tulane SCPHTM have been a tremendous asset for our office and vice versa. Mentoring these students allows for greater realistic expectations of the complexities they will face once in the field of public health preparedness. Many of their

contributions/projects are still in place today serving as plans (or pieces of plans) for the City of New Orleans. Superb student projects have included assistance in the City Assisted Evacuation Plan (the same one which was activated to evacuate 97% of the entire city in 2008), the Cities Readiness Initiative (which was scored as one of the top plans by the CDC in recent years), the Metropolitan Medical Response System, and community outreach events covering general public health preparedness as well as medical special needs preparedness. (*City of New Orleans Office of Homeland Security and Emergency Preparedness*.)

- *[Identifying phrase deleted]* for the agency's emergency response. The knowledge and skills have assisted me tremendously over the years. Responses include Hurricane Katrina/Rita, Gustav/Ike, as well as H1N1 and the Gulf Oil Spill. (*Louisiana Office of Public Health*)

- 2011 tornadoes in Mississippi including the near decimation of Smithville. The MSDH worked extensively with the SCPERLC to prepare for NLE 2011 (new Madrid Earthquake Scenario) over the last year. This preparation included meetings with local ESF-8 partners around the state to help further planning and identify resources necessary for a catastrophic response. In addition, relationships were renewed and developed with our local partners in ESF-8. During the local and state response to the tornadoes this catastrophic planning and relationships were instrumental in the response. (*Mississippi Department of Health*)

- 2011 historic flooding of the Mississippi River and its tributaries. The MSDH worked extensively with the SCPERLC to prepare for NLE 2011 (New Madrid Earthquake Scenario) over the last year. This preparation included meetings with local ESF-8 partners around the state to help further planning and identify resources necessary for a catastrophic response. In addition, relationships were renewed and developed with our local partners in ESF-8. During the local and state response to the historic flood this catastrophic planning and relationships were instrumental in the success of the response. (*Mississippi Department of Health*)

SCPHLI

- The networking among peers and the leadership coaching has made a tremendous positive impact in my current role. I attended SCPHLI in [in a previous cohort) and was promoted during that time frame. I communicate/consult with my "class scholars" on a regular basis to discuss current events and initiatives. (*Louisiana Office of Public Health*)

- The 2010-2011 Louisiana cohort of the SCPHLI was a dynamic group. There were 10 scholars but two were unable to complete the program due to circumstances beyond their control. They worked as a team and were very much involved in the sessions as well as the group project. Their group project was titled OPH LEAD (Learning for Enrichment, Action, and Development), and it focused on developing a mentoring program designed to engage/develop new or future leaders. Even facing the same amount of work on the project

with fewer people as well as keeping up with their own work, they persevered and developed an excellent tool that can be used by the agency, especially since we continue to face staffing shortages due to lay-offs. (*Louisiana Office of Public Health*)

- The 2011 tornadoes in Mississippi was a no-notice event that occurred while the designated Incident Commander was out of state on business. A SCPHLI participant was chosen to lead the ESF-8 response for Mississippi. His training and common sense approach to the response supported the needs of local governments that were impacted including the first deployment of the state mortuary team. (*Mississippi Department of Health*)

- As a former LI graduate, I utilized the information derived from the studies to evolve into a stronger public health leader. After seeing the benefits/merits of the program first hand, I sent numerous new public health managers to the LI. The LI is an excellent resource for training the future leaders of public health. The networking opportunities among the state's representatives [are] invaluable. Having well trained public health leaders has made my job easier and has made my department run much more efficient and effective. (*Mississippi Department of Health*)

DISCUSSION AND CONCLUSIONS

As a sample for this survey, members of the SCPHP Advisory Board represented an ideal group of key informants to provide meaningful input regarding the extent to which the SCPHP functions effectively as a partnership and its centers provide mission-specific and value-added training and education for public health workforce development in the SCPHP region. The critical incidents/stories of impact were particularly important, as the examination of transfer of learning from training/education to real-life professional practice and impact is often quite complex and not easily determined with quantitative measurement.

The survey data were interpreted within a larger context of participant observations of academic-practice partner interactions and ongoing informal feedback. Considerable consistency was observed in both quantitative and qualitative findings. These results were equally consistent with ongoing direct observations and interactions with academic and practice partners that were part of ongoing evaluation processes during the year-long 2010-2011 project period. Simply said, there were no big surprises. As has been the case in previous years, participants' responses provide evidence that the SCPHP and its centers are responsive to workforce development needs of its partners and training/education contributions add value to partners' local efforts to meet professional responsibilities to its employees and to its communities. The lack of responses or "not applicable" responses to qualitative items reflecting needs and improvements could be interpreted as positive endorsement of the effectiveness of the SCPHP and its centers meeting current and anticipated workforce development needs.

The critical incidents/stories of impact that were shared by respondents provided specific examples of how SCPHP-sponsored training/education impacted directly on-the-job performance.

Some of these stories provided quite powerful evidence of impact. For example, the stories relating the tornados and flooding in 2001 depicted the impact of training and partnership on emergent, high-stakes situations affecting numbers of public health professionals and citizens. While less dramatic, but clearly as important, stories relating to networking among SCPHLI graduates and development of strong, long-standing relationships among partners and others provide evidence of long-term enhancement of ongoing processes related to job performance and professional development. The overall evaluation results also revealed some important perspectives that might be considered for future program planning and improvement.

First, there appears to be increased attention on using systematic, performance-based approaches to workforce development across the state partner agencies, particularly in terms of annual training/education plans for individuals and specific staff groups/categories. Similarly, there seems to be a desire to establish threaded or connected training programs, and as applicable, multi-tiered workforce development training/education curricula that can be used to guide or scaffold ongoing professional development across career stages. These results align with findings from the 2009-2010 overall program evaluation results, only with seemingly greater emphasis, particular in terms of learning how and gaining assistance in developing, using, and evaluating such planned training/education. The findings also reinforced topics of discussion that have occurred at face-to-face Advisory Board (and Executive Committee) meetings and in conference calls. In part, the results and recommendations of training needs assessment that was completed as part of the 2010-2011 overall program evaluation can be used to design and assemble standardized training/education plans for particular individuals or staff categories. In some case, new or more advanced versions of specific training courses or exercises may need to be developed to achieve fully developed tiered or scaffold learning series that accommodate professional advancement. As is typical in the SCPHP, academic and practice partners working together in this venture can achieve high quality, professionally relevant workforce development educational programs. These, in turn, can be incorporated into the annual training/education plans that are apparently becoming standard practice within the various public health agencies. Doing so would address the apparent interest among practice partner agencies to enhance the alignment between agency-directed training/education plans and the existing and future courses, seminars and other resources available from the SCPHP centers. (e.g., certificate programs).

Second and on a related note, there is also a desire to prepare supervisors and managers with specific knowledge and skills for how to interact effectively with their subordinates to facilitate their achievement of intended outcomes of such plans. This expressed interest reiterates a professional development initiative identified in the 2009-2010 overall program evaluation. While there is still a need and much valued contribution of training/education in core public health and emergency preparedness and response knowledge and skills, the emerging training/education needs also reflect increased attention for enhancing the processes of leadership, mentoring, and workforce development for short-and long-term staffing (e.g., workforce entry, advancement, and succession planning). Said another way, having both quality training/education resources and well-prepared individuals to lead and facilitate quality use of these resources are critical to maximizing impact on both workforce development and performance across the career stages and

the various responsibilities of public health practice. These types of training/education needs span the missions and types of expertise for all of the SCPHP centers.

Third, the current array of training/education delivery options continues to meet the workforce development needs with each of the center-based areas. The quantitative results (Table 4) support continued use of the various formats and qualitative results did not suggest removing or adding options. Given the common observation that "to teach is to learn twice," and the expressed need for tiered or scaffold training/education series, train-the-trainer initiatives, advanced, "hands-on learning," and skills development in effective mentoring and coaching may contribute to achieving the needs and suggestions mentioned in the previous paragraph. Consequently, while all current formats and resource types seem valuable, the proportion and balance among each of these may need to change to accommodate specific goals and outcomes of subsequent years in the SCPHP and its centers' operations.

Finally, communication is a persistent challenge that is often evidenced in these annual program evaluation studies. Communication is contextual and influenced by both individual and organizational features. One narrative response suggested enhancing communication (e.g., by enhancing email or adding a listserv) and another suggested further consolidation of LMS systems. One option that might be considered by the SCPHP is to establish a RSS feed and/or blog to push information about training/education resources and opportunities to targeted individuals or groups. Other social media might also be explored to make it easier to reach individuals. Decisions will clearly be influenced by the vast range of generations and technological variations among both academic and practice partners in the SCPHP. Whatever new options might be considered, a small-scale pilot project might be considered, as most assuredly, some type of training and early support would be likely needed. Regarding the desire to have a single LMS for all training at all levels and sources (i.e., local, state, regional, national), this is beyond the capacity of the SCPHP alone, but there may be options that come close that could be used or opportunities for the SCPHP and its partners to advocate for such a venture through professional and funding networks.

STUDY LIMITATIONS

This report summarized the results of an end-of-year survey of key informants who are well-informed about both the SCPHP and its centers' operations and contributions to their respective agencies. This survey and other overall program evaluation components previously mentioned were conducted for the explicit use of findings to support the ongoing development and success of the SCPHP and its centers. The extent to which these findings are generalizable to other similar partnerships and training programs would depend on their similarity. However, even within this focused program evaluation context, there are limitations to be considered. For this study, we relied on a small sample of well-informed participants and achieved a less-than-desired response rate (34.38%). The extent to which the perspectives of the respondents are representative of the larger SCPHP practice partner community is a potential limitation. However, the findings are highly consistent with those obtained in other evaluation components. The training needs assessment study, interactions with the entire Advisory Board in face-to-face meetings and periodic conferences calls have involved many more practice partner representatives and the academic partners and the consistency among these interactions and the finding reported here suggest that

the results reported here can be used to guide future developments and improvements for the SCPHP and its centers. Further, as is always the practice, the results of this study will be vetted with the academic and practice partner stakeholders as part of the decision-making process and planning for 2011-2012.

A second limitation to consider is the extent to which participants were comfortable providing critique. Clearly, the results are very positive and almost all ratings for quantitative items were near the top of the response scales. Therefore, can we trust that all is as positive as these results suggest? Were there participants who had negative views or significant critique that did not respond? Were those who did respond simply those who are most positive about the SCPHP and its centers? This is certainly possible and would reflect an important limitation for both using the results for future program development or for generalizations to other contexts. First, the less-than-desired response rate is not unique in this type of evaluation activity when used in annual program evaluations for the SCPHP since 2000. Partners are busy and have shared previously that if satisfied with the status quo, there is less felt need to respond. Anecdotally, as one partner shared, participation is voluntary, so when other work responsibilities are required and time is limited, the work expectations receive priority. Second, there is a long history between academic and practice partners and this evaluator. Past and current behaviors have demonstrated consistently that stakeholders are very comfortable being frank in providing input, regardless of whether information is gathered anonymously, confidentially, or face-to-face. Their candid responses have consistently demonstrated trust and openness with the evaluator. Therefore, this evaluator feels confident that respondents were candid and complete.

CONCLUSION

The SCPHP continues to be perceived by practice partners as a responsive, valuable, and effective partnership. Each of its centers is similarly valued and there is motivation among key practice partners to increase the use and impact of the centers' resources and offerings for training/education. Critical and emerging needs reflect a need for training at higher levels of performance and the use of scaffold-type curricula. Similarly, there is increased need for supervisory, management, and leadership development in the processes of ongoing professional development (e.g., training/education plans, mentoring, coaching, evaluation and feedback). Development and delivery of these types of training and education may require increased use of in-person/on-site training, train-the-trainer models, and/or targeted technical assistance, in addition to combinations of these with existing or new web-based courses or seminars. Common areas of workforce development needs may facilitate development of training models and activities for the region. With collaboration of all relevant stakeholders, adoption or adaptation of a regional model could then be used across stakeholders' organizations or within a state, city, or county-level organization. Further, the positive network of relationships among partners would likely facilitate diffusion of such innovations and ongoing professional support among leaders for sustaining programs and processes.