

UNIVERSITY OF UTAH

Partnering with Community College Educators to Build Pathways to Disease Intervention Certification



CENTER FOR PUBLIC HEALTH
**WORKFORCE
DEVELOPMENT**
— ASPPI

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Project Purpose and Background

Disease intervention (DI) professionals are an essential part of the public health workforce, supporting the prevention and control of infectious diseases through activities such as case investigation, contact tracing, partner services, care coordination, outbreak response, and community engagement. Although DI work has historically focused on sexually transmitted infections (STIs) and tuberculosis (TB), DI professionals increasingly support responses to emerging and re-emerging public health threats. As the scope of disease intervention has expanded, so has the need for a standardized approach to preparing, training, and recognizing this workforce.

To address this need, the Centers for Disease Control and Prevention (CDC), in collaboration with national public health partners, initiated efforts to establish the Certification in Disease Intervention (CDI) program. The CDI program is designed to standardize and validate the knowledge, skills, and abilities of DI professionals, improve the quality and consistency of disease intervention services, and strengthen recruitment, retention, and professionalization of the workforce.

The CDI project has advanced through several phases over more than a decade. In 2013, CDC and the National Association of County and City Health Officials (NACCHO) collaborated on a feasibility assessment to evaluate the potential for a national DI certification program. NACCHO supported stakeholder engagement and contracted with International Credentialing Associates to assess workforce needs, training gaps, operational requirements, and sustainability considerations. Beginning in 2014, the Public Health Accreditation Board (PHAB) served as the coordinating organization for the assessment phase, leading foundational activities such as the DI workforce registry, Job Task Analysis, workforce enumeration studies, and evaluation of certification models. This work helped define DI competencies and supported the selection of a test-based certification model.

In 2022, the Association of Schools and Programs of Public Health (ASPPH) assumed leadership of the CDI project through a CDC-funded cooperative agreement. In partnership with the National Board of Public Health Examiners (NBPHE), subject matter experts, and national public health partners, ASPPH has supported certification infrastructure, examination development, stakeholder engagement, and strategies to strengthen pathways into the DI workforce.

As the CDI program moves toward implementation, establishing accessible educational pathways into the DI profession has become increasingly important. Community colleges serve a broad population of learners and provide flexible educational opportunities that can strengthen workforce recruitment and expand access to careers in public health. Leveraging community college programs as entry points into the DI workforce has the potential to increase workforce representation, improve geographic reach, and create sustainable pathways to CDI certification.

To support these efforts, ASPPH awarded a subaward to the University of Utah to design frameworks, models, and recommendations for educational pathway programming that prepares community college students to enter the disease intervention workforce and pursue CDI certification. The project focused on identifying pathway models aligned with DI job domains and tasks while emphasizing flexibility, accessibility, and scalability. By exploring how community colleges can contribute to workforce preparation and certification

readiness, this work seeks to strengthen recruitment, training, and retention efforts and support the development of a representative and sustainable disease intervention workforce. The findings and recommendations from this project are intended to inform future efforts to establish community college-based educational pathways that support both entry into the DI profession and long-term participation in the CDI certification program.

List of Abbreviations

AS	Associate of Science
BS	Bachelor of Science
CC	Community College
CDI	Certified in Disease Intervention
CEH	Continuing Education Hours
CHW	Community Health Worker
CHL	Community Health & Leadership
DI JTA	Disease Intervention Job Task Analysis
DI	Disease Intervention
HIPAA	Health Insurance Portability and Accountability Act
PUH	Public Health
SES	Socioeconomic Status

Detailed Report

Objective

The overall objective for this project is to provide a framework that Community Colleges (CCs) can use to assess their readiness to provide training that prepares students to sit for the CDI exam. The framework covers existing coursework readiness, as well as the feasibility of formal programming that supports DI professional training at the college and the student level. A brief description of the methods is provided below, followed by a summary of all data collection (Table 1).

- **Coursework readiness** was assessed by mapping course syllabi from four organizations and select assignments to the draft Disease Intervention Job Task Analysis (DI JTA) domains. Reported metrics included (1) the percentage of job tasks and knowledge mapped to coursework, and (2) additional tasks identified in the listening sessions with employers. Recommendations for addressing gaps in the DI JTA were provided based on the methodology of Mase et al. (2018), resulting in suggestions for coursework and practical training that could be implemented at the CC level.
- **Program readiness** was assessed by holding listening sessions with faculty and staff at two colleges. Using the feasibility assessment proposed by Bowen et al. (2009), we asked them about concepts of acceptability of, and demand for, DI professional programming; the ability to implement DI professional requirements into existing programming, including necessary adaptations; resources needed for existing implementation and future scale-up activities; and perceptions of how certificate programming could increase the diversity of the DI professional workforce. Thematic analysis was used to develop recommendations to guide CC-level discussions about their readiness.
- **Student supports** were assessed by holding listening sessions with faculty, staff, and students at two colleges. Three broad areas of support for student success were identified by Mantai & Dowling (2015) and framed these discussions: social, academic, and instrumental support. Thematic analysis was used to develop a series of questions and assessments for consideration by CCs about the types of student supports that exist or that may need to be developed to assist students in enrolling in and completing training that prepares them to sit for the DI professional certification exam.

Table 1. Methods of data collection

Aim	Participants		
	Employers of DI Professionals	College A & B	College C & D
1: Map CC education pathways using existing coursework	Listening session	Syllabus & assignment mapping	<i>Syllabus & assignment mapping</i>
2: Assess potential feasibility issues for DI professional programming		Listening session	
3: Identify student supports for DI professional certification		Listening session	

CC: community college

Methods/Activities Undertaken

Participant Sample – educational organizations selected for mapping (Aim 1)

Purposive sampling (which selects a specific group of subjects for analysis) for maximum variation was selected to document “unique or diverse variations that have emerged in adapting to different conditions, and to identify important common patterns that cut across variations” (Palinkas et al., 2015; Patton, 2002). With maximal variation sampling in mind, we originally selected three organizations for inclusion in our assessment: College A, College B, and College C. Each has a strong tradition of successfully working with communities disproportionately affected by social and economic conditions contributing to health. Their expertise informed our understanding of existing and needed curriculum for DI professional training at the CC level and provided insights into feasibility concerns, which included improving regional representation among the DI professional workforce. A fourth institution was added, College D, based on input received during our employer listening session, which allowed us to map a certificate for Community Health Workers (CHWs), who were seen as a natural fit for DI professional training and certification.

Table 2. Purposive sample to maximize variation among institutions in terms of campus location, curriculum levels being taught, teaching modality employed, and student priority population(s)

Organization	Location	CDI-related Curriculum			Teaching Modality	Priority Population(s)
		Certificate	AS	BS		
College B	Rural	X	X	X	In-person & online	Native American, first generation
College D	Urban	X			In-person for CHW	Pacific Islander, first generation, CHWs
College A	Urban		X		Predominantly online for CHL	Hispanic, first generation
College C	Online	X			Fully online	Workforce

CHL: Community Health & Leadership degree, CHW: Community Health Worker

College B: Originally established in 1968, today the college has five campuses and two microsites across three states. It offers both a two-year Associate of Science (AS) degree and a certificate in *Public Health*, both of which emphasize tribal concepts of health and wellness. With an existing Bachelor of Science (BS) degree in *Public Health*, College B is also an established dual-mission institution. The geographic area the college serves is designated by the US Census Bureau as frontier (sparsely populated and geographically remote), representing the dual challenges of geographic barriers to educational attainment and small program size (approximately 2,000 students in total). In addition to serving learners from a community historically under-represented in the health system, College B has experience in rural education, which includes reliance on videoconferencing technology to increase student access.

College D: A small (approximately 7,000 students) public community college, it was originally established in 1946 as a technical school to support tourism. The mission of the institution expanded in the 1960s to include general education and health education programs. College D’s vision focuses on producing graduates who can lead the social and economic advancement of the people of Hawai’i. Among its 84 degrees and certifications is a 16-credit Certificate of Competency for Community Health Workers (CHWs), available through the College of Health Sciences. College D was added specifically because employers in the listening session noted that CHWs could be cross-trained as DI professionals, giving them similar skills that could enable their employment beyond surge capacity during infectious outbreaks.

College A: College A serves a broad population of 50,000 students at eight locations and online, including a number of first-generation college students and Hispanic students. College A's vision is to support its served communities by enabling its students to gain successful employment and/or transfer to another further education activity. College A offers a new two-year AS degree in *Community Health & Leadership*, and uses articulation agreements (formal partnerships between institutions) to facilitate the transfer of students to BS degrees with four-year colleges in the state. Additionally, the college has an active Area Health Education Center that offers programming to both high school and undergraduate students. Thus, College A provides insights on pathways from high school to two-year and four-year training.

College D: Following a continuing education model with certification, this college's program has extended the role of DI professionals to incorporate the skills needed for the COVID pandemic response. This continuing education model, often used by CCs, fits well with the recommendation for national test-based certification (PHAB, 2017) and could be an entry point for DI professional training and a bridge to education at the associate level. College D's experience in expanding DI professional training during the pandemic demonstrates the potential for similar program expansion across the nation. During the course of this project, College D's curriculum was no longer available live, but we obtained access to its course modules to map its curriculum for the purposes of this project.

Mapping Courses

Because the recent DI JTA was in progress while this project was ongoing, we used a preliminary version of the DI JTA to identify tasks in which DI professionals should be proficient. Members of the project team reviewed titles and descriptions for courses leading to the selected degrees (Public Health AS and BS at College B; Community Health & Leadership AS at College A; CHW Certificate at College D). They also reviewed titles and descriptions for all modules at College C. In consultation with employees at each organization, the courses chosen for mapping were those whose content was most likely to cover DI JTA tasks, and we requested syllabi and associated assignments for these courses.

Pilot mapping

Two team members from University of Utah (KG, LG) and two from Salt Lake Community College (SLCC) (JH, MB) independently mapped syllabi from College A's courses to create a codebook and mapping procedures, with each mapping the same Community Health Leadership course and some mapping an additional course. The four team members mapped course objectives, competencies, activities, and assignments to specific DI JTA domains and tasks (i.e., the standard; DI JTA draft provided 12/17/2024). The project team held three meetings, using in-person and Zoom formats, to discuss the course-mapping process and development of the codebook. These meetings were used to discuss process discrepancies and to develop procedures that could help standardize the mapping process.

Full mapping

The course descriptions of classes taught by all four participating organizations were reviewed, and for those courses whose descriptions aligned with DI professional-relevant criteria, syllabi were requested. Course objectives, competencies, activities, and assignments were independently mapped by three team members (KG, JDP, MB) in order to capture and document knowledge and competencies/skills. This included College A courses that were previously mapped during the pilot, to ensure that they were mapped according to the finalized protocol. Discrepancies between independent mapping activities were discussed and resolved through an iterative comparison process, and resolutions were documented in Excel (Creswell & Poth, 2018; Mase et al., 2018). Unreconciled differences were addressed through discussion with a third team member (LG) and resolved by consensus. Final decisions were documented in the Excel file. All data files were stored in a secure, HIPAA-compliant cloud platform (Microsoft Teams). Courses mapped for each organization are described in Table 3.

The output for this activity was the percentage of mapped DI JTA domains for each course. Each domain encompassed a number of specific tasks within the DI JTA format. The domains were: (1) planning and case

analysis; (2) interviewing and case management; (3) field services and outreach; (4) surveillance and data collection; (5) collaboration; (6) outbreak response and emergency preparedness; and (7) public health sub-principles, which our project team added so as to encapsulate the “public health principles” category at the end of each DI JTA domain. The output for this activity was the percentage of mapped JTA domains for each institution. For the numerator, we counted any instance (knowledge, competency, task, activity, or assignment) where a course mapped to a specific task. The denominator was the total number of tasks evaluated. Thus, each calculated percentage represents the percentage of tasks covered for per institution.

Table 3. Courses included for mapping

Course No.	Course Name	# of Credit hours
College A		
CHL 2010	Health & Disease	3
CHL 2500	Community & Public Health	3
CHL 2800	Healthcare Systems	3
College B		
<i>Associate's degree</i>		
PUH 111	Introduction to Public Health	3
PUH 200	Principles of Health Education	3
PUH 220	Health and Human Disease	3
<i>Bachelor's degree</i>		
PUH 355	Health Disparities	3
PUH 356	Health Services and Policy	3
PUH 380	Implementation and Evaluation of Public Health Interventions	3
College D		
CHW 100	Community Health Worker Fundamentals	3
CHW 130	Introduction to Counseling & Interviewing	3
CHW 140	Case Management for CHWs	3
College C		
	Disease Intervention	2 CEH
	Outbreak Management	8 CEH
	School Specialist	8 CEH
	Cultural Humility	13 CEH
	Vaccine Communications	6 CEH
	Case Studies in Outbreak Management in K-12 Schools	2 CEH
	Targeted Telephone Outreach, Health Education, and Resource Coordination for People Living with Long COVID	6 CEH
	COVID-19 Treatments	3 CEH
	Essential Interviewing Skills for Disease Intervention	24 CEH
	Mpox Disease Intervention	7 CEH
	Tuberculosis Interview Training	UKNW
	Epidemiology 101	4 CEH

CHL: Community Health & Leadership degree, CHW: Community Health Worker, PUH: Public Health

Each domain contained a public health-related DI JTA category titled “Adhere to public health principles during [Domain Name Here].” This job task was viewed as more useful when distinguished as part of unique public health principles and, subsequently, we treated each as an individual job task. This approach captured the main concepts and skills associated with this repetitive DI JTA task within each of the domains. This led

to the creation of five additional points for mapping under a newly created category of Public Health Sub-Principles: (1) HIPAA/confidentiality; (2) social awareness; (3) basic epidemiology; (4) understanding social and economic conditions contributing to health; and (5) ethical and professional conduct.

Participant Sample – listening session protocol and participants (Aims 2 & 3)

Three groups were targeted for listening sessions: employers of DI professionals, faculty and staff at select colleges, and current health science students. All listening sessions were conducted via Zoom video call and were recorded. Recordings were transcribed using HappyScribe software. Written transcriptions were reviewed by a team member for accuracy and corrected as needed. Personally identifiable information was removed from the transcripts. Audio files, transcriptions, and analytic notes were stored in a secure, HIPAA-compliant cloud platform (Microsoft Teams).

Employers

Two employer listening sessions were held with participants from state and local health departments, due to their likelihood of employing DI professionals. Convenience sampling was used to identify potential participants known to the project team, who in turn identified others in their organization who might provide sought-for insights. Maximum variation sampling was employed with the goal of ensuring a meaningful range of perspectives by role and location. Stakeholders represented public health departments at the local and state level in California (n=6), Utah (n=6) and Navajo Nation (n=<5) (Table 4). We also included several people from the California Prevention Training Center (CAPTC), given its role in training contact tracers for the state of California during the COVID-19 pandemic. A question guide was used by the moderator to ask participants about the skills needed in the DI JTA domains and to give them an opportunity to discuss other critical skills required during a disease outbreak. Listening sessions lasted 60 minutes. The question guide can be found in Appendix A.

Table 4. Participating Employer Categories for Certified in Disease Intervention Listening Session on Workforce Skills and Training

	Navajo Nation	Utah	California	Total
DI Professional	<5	<5		<5
State Health Department		<5	<5	6
County Health Department		<5		<5
California Prevention Training Center (CAPTC)*			<5	<5

Faculty & Staff

Two faculty/staff listening sessions, one for College B and one for College A, were conducted via Zoom to gather data on instructional formats, student support, educational and career pathways, and the feasibility of adding DI professional training to the existing curriculum. The listening session with College A included one faculty member, one dean, and one wellness team member. The College B listening session included two full-time faculty members, one adjunct faculty member, and a career academic advisor. Listening sessions lasted 60 minutes. See Appendix B for the listening session question guide.

Health Science Students

Student listening sessions were conducted at College B (n=5 participants) and College A (n=9 participants) and included current health science students or recent graduates. Sessions lasted 30 and 50 minutes and were conducted via Zoom. Listening session participants received a \$25 gift card for Amazon or Target as compensation for their participation. These listening sessions focused on gathering data on instructional formats, student support, and educational and career pathways. See Appendix C for the student listening session question guide.

Results/Recommendations

Mapping

The percentage of courses that mapped DI JTA knowledge and skills at each organization is provided in Table 5. Knowledge was more commonly mapped (range: 21.3-72.3%) to courses than skills (range: 0-66.0%). Where available, assignments outlined in syllabi were also mapped to DI JTA to document more specifically whether skill development was assessed. These are included in the calculations for Table 5.

Throughout the process of mapping course syllabi, it became apparent that course objectives were effective at illustrating *aspirational* knowledge and skills-based development. However, analysis of syllabi did not provide confirmation that DI JTA tasks had been assessed or that students possessed specific skills. This is in contrast to the findings of Mase et al. (2018), who mapped coursework directly to DI JTA tasks at a single university in bachelor's and master's degree programs and reported higher mapping alignment than we report (range for bachelor's degree in public health: 75-100% for DI JTA tasks and 43% for knowledge). In addition to mapping to degrees above the associate's degree, the authors were affiliated with the university. It is possible that, due to their familiarity with the course content, Mase et al. (2018) inferred a higher percentage of DI JTA tasks that mapped based on their syllabi than we found. In our pilot, the person who taught the classes was more likely than other team members to map tasks using only the syllabus because of their detailed familiarity with course content, which extended beyond the descriptions in syllabi and assignments. As a result, we mapped all course materials for this project using team members who did not teach the courses.

KEY FINDINGS: Given our finding of the difficulty in mapping most syllabi, it is recommended that educational institutions use syllabus and assignment development criteria that include intentional mapping to a DI JTA framework. This will ensure that course developers and instructors can clearly connect tasks performed by DI professionals to learner knowledge and skills development throughout the course, as demonstrated in the highly task-targeted training provided by College B. In addition to syllabi calling attention to knowledge acquisition, it can be beneficial to identify specific skills at the conclusion of the course, whether those are demonstrated during group activities or in presentations and reports. These specific skills should also be noted in relevant assignments. As part of our framework development for evaluating whether to implement DI professional training at CCs, we identify an approach to mapping that incorporates the use of the DI JTA at a secondary stage of mapping activities.

Table 5. Alignment of Community College Courses with Certified in Disease Intervention Job Task Analysis Domains

	JTA tasks	College A (three courses)			College B (six courses)			College D (three courses)			College C (12 courses)		
		Knowledge (n)	Skills (n)		Knowledge (n)	Skills (n)		Knowledge (n)	Skills (n)		Knowledge (n)	Skills (n)	
Planning and Case Analysis	6	1	3*		2	2		1	0		4	4	
Interviewing and Case Management	15	8	2*		4	1		3	0		14	13	
Field Services and Outreach	10	0	0		2	0		0	0		4	1	
Surveillance and Data Collection	4	1	2*		1	0		1	0		3	2	
Collaboration	4	1	0		1	1		1	0		1	3	
Outbreak Response and Emergency Preparedness	4	3	1*		0	0		1	0		3	4	
Public Health Sub-Principles	4	1	2		3	3		3	0		5	4	
Total n (%)**	47	15 (31.9)	10 (21.3)		13 (27.7)	7 (14.9)		10 (21.3)	0 (0)		34 (72.3)	31 (66.0)	
General Public Health Sub-Principles													
HIPAA/Confidentiality		N	N		N	N		Y	N		Y	N	
Social Awareness		N	N		N	Y		Y	N		Y	Y	
Basic Epidemiology		N	Y*		Y	Y		N	N		Y	Y	
Understanding social and economic conditions contributing to health		Y	Y		Y	Y		N	N		Y	Y	
Ethics		N	N		Y	N		Y	N		Y	Y	

JTA: job task analysis

*Skills map to the JTA if infectious disease is selected for the assignment.

**The total % represents the percentage of JTA tasks covered by the combined courses mapped from the institution listed.

Listening Sessions

Employers

Employers expressed a favorable outlook on CCs as the appropriate academic level for DI professional training, where typical wages and skills are commensurate with certificate or associate's level training. Some employers expressed skepticism about the ability of an academic program to teach skills that they felt might be better acquired in on-the-job training. Employers generally identified a six-to-18-month timeline in the workforce as necessary for adequately training DI professionals, with some employers advocating for the longer timeline because of their view that considerable on-the-job training would be required.

Employers also shared views of the added benefit of a well-trained DI professional workforce. Examples included better retention due to applicants' realistic expectations of what the DI professional position entailed, lower onboarding costs and shorter training time for newly-hired CDIs (relative to non-certified employees), and a potential pathway for growth and promotion.

Coursework viewed by employers as most beneficial included epidemiology, disease pathophysiology, outbreak response, HIPPA and mandatory reporting, and medical terminology. Other critical skills, including social awareness, "street" smarts, motivational interviewing, and disease investigation, were viewed by employers as more appropriately learned through on-the-job training.

KEY FINDINGS: Employers advocated for DI professional certification to be housed within two-year training, whether as part of a formal degree or as stand-alone certification leading to national certification. We also recommend that—in contrast to employers' perceptions—many of the critical skills they mentioned, often termed "soft skills" (recently reframed as durable skills), can be taught both didactically and experientially. In one article, Kelly Dore, PhD, noted the value of durable skills in health teams: *"Specific technical skills may lose relevance over time, underscoring the value of foundational and durable skills like empathy, ethics, flexibility, collaboration and maintaining a growth mindset. Especially within diverse teams, creatively addressing unforeseen challenges and applying knowledge innovatively is essential. Not only that, but durable skills serve as transferable skills across industries. These will be the key determinants of success in today's world."* (Robinson, 2023). Attention to developing and evaluating durable skills will be important in initial and ongoing training for DI professionals, while their acquisition can be important as a bridge to future educational and employment opportunities. Additionally, comprehensive inclusion of evidence-based pedagogical methods across all coursework may improve career success for certificate earners, as learning how to be an on-the-job learner is itself a skill that can be taught in an academic setting. Examples of such methods include metacognitive learning strategies, experiential learning cycles, collaborative learning structures, scaffolded independence training, and problem-based learning.

Faculty and Staff

Overall, both College A and College B viewed the feasibility of implementing a DI professional training program at their respective colleges as high. Results from the faculty and staff listening session provided insights into each of the feasibility guidelines outlined in Table 6.

Table 6. Rating of Positive (+), Neutral (+/-) or Negative (-) for Perceived Feasibility of adding a Disease Intervention Professional Programming at College A and College B

Feasibility Guideline	Question Guide Prompt (To what extent would a DI professional training program...)	College A	College B
Acceptability	...be judged as suitable (satisfying, attractive) to your existing program(s)? To students?	+	+
Demand	...be used/accessed by students?	+/-	+/-
Implementation	...be able to be delivered as intended?	+/-	+/-
Practicality	...be implemented using existing resources?	+	+/-
Adaptation	...require changes be made to existing infrastructure and processes?	+	+
Integration	...be integrated within your existing educational system?	+	+
Expansion	...be expandable to new sites? (within or external to your system)	+	+/-
Limited efficacy	...show promise for increasing representation within the DI professional workforce?	+	+

Acceptability. Faculty and staff expressed confidence that a DI professional program would be viewed as attractive to students. Both colleges saw the potential for this certificate to enable skill stacking (developing knowledge and expertise in multiple areas) to increase student’s employability.

“I definitely think the certification would add to their credentials and credibility to entering into some of these jobs.”—Faculty/Staff Listening Session Participant

College A participants viewed the certificate as a distinguishing factor for students enrolling in highly competitive merit-based programs, such as nursing and dental hygiene. The college’s Dean of Health Sciences suggested that the DI professional program could be included as part of the point system, which ranks applicants for such competitive programs.

Demand. The biggest concern, expressed in both listening sessions, was whether this certificate would open up more job opportunities for students. College B faculty worried that students who received their AS in public health with a DI professional certification would expect more job opportunities than are currently available.

“We look at it from the other end of the how—how would this lead into a job for someone? And I think as a standalone, maybe at this point [that] might not be the case, but I think adding it as part of a class, you know, like as you’re taking this class, you’re learning some of the principles of what a [DI professional] does and then that allows you to be eligible to take the exam afterwards. I think that’s probably the route that I would take, at least at the community college, from what I understand. But the job piece is what usually gets me. You know, will this certification lead to a job? What does that look like?”—Faculty/Staff Listening Session Participant

A big unknown for faculty and staff was how to gauge the demand from students for a DI professional training program.

“I definitely would say that it would help them in increasing their chance in being able to be employable. But actually capturing that number of how many students it would be successful for. It’s really dependent upon our students. And their drive for their career pathways.”—Faculty/Staff Listening Session Participant

Despite faculty and staff being neutral on the perceived demand of a DI professional training program amid variable workforce and regulatory demands, students—especially from College B, which participated in the

student listening session—showed great interest and excitement about the potential to participate in a DI professional training program at their college.

“I think a program like this would be very helpful for us because not only will we get the training or get certified, it would help us understand our community a little bit more, too, with contact tracing, infection, infectious disease, things like that.”—College B Student Listening Session Participant

Implementation. Both colleges believed they could implement the DI professional program. However, their comments demonstrated a lack of understanding of the depth of the DI JTA, which could potentially be more challenging or comprehensive to implement than they imagined. Team members’ inability to share the detailed DI JTA with participants may have contributed to this misunderstanding. If the DI JTA were available to faculty, we believe they could map their curriculum and embed the DI professional training program into their existing courses with some new tasks added to the courses, or perhaps the creation of one additional course.

“But, well, this could possibly be done in this course. This skill might fit in that course. And when that process is done, okay, what skills are orphaned, essentially. What do we need to develop or consider if we are going to try and ensure those skills are covered? At what level is that necessary? Is that appropriate? Is it a 200-level course or is it a [400-level] course?”—Faculty/Staff Listening Session Participant

Practicality. Both colleges had existing courses for which (as noted above) adding or fine-tuning assignments to meet the DI JTA would allow streamlined implementation. College A saw its community engaged learning initiative as a valuable resource in creating more hands-on learning experiences for students enrolled in courses already setup to incorporate DI JTA tasks.

“One thing I can suggest is just looking a little deeper at the [course title] that’s becoming a community engaged learning course... We would be doing the vaccine campaigns and the vaccine clinics... We could even think about partnerships with local health departments, with the state, if they’re doing any kind of outreach and community engagement for specific public health disease intervention kinds of campaigns, that those could become other projects as well... I was imagining... weekend executive sessions, where they learn about the contact tracing and they learn about things that they may or may not have been able to be exposed to in their [course] project.”—Faculty/Staff Listening Session Participant

Adaptation. College A and College B saw little need for significant changes in curriculum and program structure to provide the DI professional training for their students.

“I could see a revision of coursework that might do things like motivational interviewing and those sorts of things so that when students who have completed that track and then the bachelor’s could sit for the certification exam, and they would have gotten some of the more on-the-ground skills-based [content] in the first couple of years, and they’re now eligible for using that and working, employable in that respect, and then moving on from there to more of the higher level. So that’s my perspective on it.”—Faculty/Staff Listening Session Participant

“I think it would be entirely acceptable, given we actually already have two courses, which is a one-year sequence, Community Health Assessment and Planning, followed by Implementation and Evaluation of Public Health Interventions. Now, those are taught by [instructor name]. The challenge is that these are 300-level courses. So, the bachelor’s level, not at the associate level.”—Faculty/Staff Listening Session Participant

Integration. Participants noted that the sustainability of a DI professional training program would be largely dependent on demand from students and the ability of both colleges to advertise the certification to the appropriate cohorts of students.

“To me, you could do advertising. I would probably focus more on coursework and ensuring students understood that this was something that they could do. I would envision this more as something incorporated into the existing program and then sitting for at the end rather than separate coursework. And in that case, it would be, ‘Hey, you’ve completed this degree, you’re now eligible to go take this exam’ and essentially have a certification that you can present similar to clinical professionals.”—Faculty/Staff Listening Session Participant

Expansion. Participants had varied perspectives on the ability of the colleges to expand the DI professional program, if implemented. College B did not see a need to expand the program beyond public health but did mention the possibility of working with local health organizations. College A saw expansion as a way of providing access to more students by developing and marketing it across all health-related degrees and even focusing on concurrent enrollment and Area Health Education Center (AHEC) programs.

“We can’t add additional credits to programs because they’re limited under their programmatic accreditation, but allowing it as an elective for any course, that... That’s actually really easy to do. So, we could. Building it as an elective makes it really easy to expand to multiple programs.”—Faculty/Staff Listening Session Participant

Limited Efficacy. Efficacy could include multiple metrics, but we chose to focus on the programs’ ability to enroll individuals from a variety of backgrounds into DI professional training and, ultimately, increase representation within the DI professional workforce. College A and College B are both exceptionally well-equipped to encourage greater participation in the CDI program, given their existing populations, which include high proportions of students who are first generation, rural residents and/or other population groups.

“And that is what we’ll pull into this program, is those student supports and those resources, those extended scholarships, the support and student engagement opportunities, all of that that we’ve been able to maintain and keep because we are serving [under-resourced] communities [and those with limited access].restrictions.”—Faculty/Staff Listening Session Participant

“That could have some huge impact, especially if there are more individuals from tribal communities in Public Health.”—Faculty/Staff Listening Session Participant

KEY FINDINGS: While, overall, faculty and staff viewed implementing DI professional training positively, many challenges and questions exist, and considerable work will be needed to align current curricula with the DI JTA. Concerns were raised about how to identify the need and demand for DI professional programming, as well as over the feasibility of creating a new program or building one within current curricula. One specific concern was about the difficulty of demonstrating the connection between obtaining certification and improved job placement opportunities in the current workforce. Shifts in the federal landscape, including public health-related spending priorities, were also identified as a potential barrier to implementing a certification program. The greatest immediate benefit identified by faculty and staff was skill stacking for those currently employed as DI professionals or in related positions, specifically as a means for professional development. An additional benefit noted was that certification had the potential to move students into resume-building jobs more quickly, as well as to provide meaningful employment while they were still students (an oft-noted requirement for first-generation students). Similarly, DI professional certification was seen as a way to add points on competitive academic program applications, which have

many more applicants than available positions. Challenges and benefits were viewed from the perspective of current initiatives: Participants from College A viewed the DI professional training program as a valuable addition to the program development underway, while faculty from Diné College expressed hesitancy about program expansion, largely due to the lack of institutional infrastructure needed to ensure success of existing programs (something they are still addressing).

Students

Participants from the student listening sessions included those in public health majors from College B and a range of health-related majors from College A (nursing, dental hygiene, and occupational therapy assistant). Students from College B ranged from sophomore level to recent graduates. Current students at College B included those enrolled as both full-time and part-time students and those who had participated in a mixture of in-person and online courses. College A students included those just starting their college curriculum as well as second-year students near the end of their two-year degree in health science. All participating College A students attended their courses in-person at regionally-located campuses.

The question guide (provided in Appendix C) asked students to respond to questions about three key areas of support (Mantai & Dowling, 2015):

- **Social support**, which includes emotional support, collegiality, and companionship, as well as guiding and mentoring activities
- **Academic support**, which includes access to conceptual, editorial, linguistic, and other academic resources.
- **Instrumental support**, which includes access to administrative and financial resources, as well as availability of technical or instrumentation resources needed for training.

A summary of the themes noted by students, staff and faculty is provided in Table 7.

Table 7. Examples of Student Support Available and Lacking at College A and College B as Reported in Listening Sessions with Faculty, Staff, and Students

College	College A		College B	
Participants	Faculty/Staff	Students	Faculty/Staff	Students
Social Supports	Food pantry Childcare Mental health services Health services	Childcare	Professors able to share personal skills and experience	Flexibility to work while taking online courses
Social Needs			Mentorship programs, access/resources for remote students	Greater access to childcare assistance, mentors, increased services for remote students
Academic Supports	Free tutoring Small class sizes	Helpful and accessible academic advisors	Academics willing to provide guidance with writing	
Academic Needs	Academic advisors			Academic advising
Instrumental Supports	Bruin Emergency Fund	Library resources, Federal Student Aid (FSA) office	Financial assistance/aid Scholarships	Free tuition, free books
Instrumental Needs				Grants for certification programs

The perception of value for a DI professional certificate among students from College B was very positive. Students also expressed excitement over the possibility of the added benefit to their current educational and career path.

“I think a program like this would be very helpful for us because not only will we get the training or get certified, it would help us understand our community a little bit more, too, with contact tracing, infection, infectious disease, things like that.”—Participant 3

Despite student excitement and interest in this professional certificate opportunity, particularly its potential to distinguish them among competing job applicants, concerns regarding cost, available student support, and accessibility of courses were identified as possible barriers to pursuing the certification. Students from both College B and College A provided valuable insights and feedback regarding student support at their respective locations. College B students expressed concern over the lack of support for online and part-time students relative to in-person students. Of particular concern was the difficulty of obtaining critical support services such as childcare, shuttle services from various campuses, and clear and prompt communication about mentorship and internship programs. Some College B students felt that academic advising needed strengthening before the college could successfully provide more programs; this aligned with similar faculty concerns. Faculty support was acknowledged by Diné students as extremely helpful and supportive, but there was a recognition that any expansion in programming would require the addition of new faculty. College A students identified the availability and access to academic advising, financial aid support, and childcare as critical benefits that enhanced student success at their college. It is important to note that participating students from College A were located nearer to the campus, whereas students from College B were geographically spread out and predominantly attended courses online. College A has noted a recent move to online course delivery in its *Community Health and Leadership* major, which raises potential concerns about communication timeliness and access to faculty, concerns also noted by College B students in relation to their predominantly online major.

KEY FINDINGS: The framework of social, academic, and instrumental supports allows colleges to evaluate their existing supports for students. Our listening sessions highlight the perceived benefits for among all students. Supports noted in Table 7 provide a starting point for creating a checklist to evaluate resources that support student success. Disconnects between students and faculty/staff represent areas needing either improved communication about existing resources or further resource development. Participants emphasized the need to have supports in place before (or during) the expansion of DI professional programming to ensure both student and program success.

Summary of Results and Recommendations

We found strong endorsement among employers, faculty, staff and students of the view that CCs are a good home for DI professional training. There was excitement that such training could benefit students in numerous ways by providing knowledge, skills and/or credentialing that: (1) leads to early resume-building opportunities, (2) offers the opportunity for meaningful employment during their educational journey (often a financial necessity), and (3) enhances access, through professional development, to competitive employment and educational pursuits. For CCs, these benefits align with their stated missions to train students for careers that also benefit their own communities.

Framework for Developing DI Professional Programming at a Community College

Our stated objective for this project was to design a framework for two-year degree-granting colleges to identify their existing assets and readiness to develop certification that expands the DI professional workforce overall and increases representation of DI professionals from disproportionately impacted communities. To

that end, we offer the following three-step framework for use by CC faculty, staff, and/or program directors who are considering developing DI professional training that can lead to national certification.

Step 1. Map existing or proposed curriculum

For CCs that are adding DI professional training within their existing curriculum, mapping is an important planning activity to minimize duplication of existing course content and to avoid wasted effort on course development. For CCs that are implementing completely new DI professional programming, mapping is an opportunity to see the entire program layout before committing resources to curriculum development and to ensure that all necessary objectives are included in the plan. When creating a program from scratch, blue-sky thinking can be used to freely identify goals or ideas that are unconstrained by pre-set planning requirements. However the approach can also feel complex and confusing. The guidelines below for two-stage mapping are intended to provide guidance on developing objectives while allowing some freedom to develop the program to fit the context of a particular college or major. This can be followed by mapping to specific skills needed for national certification. We recommend the two-stage approach to mapping because we found that while the DI JTA was an overwhelming starting point for mapping, it was useful for the development of specific assignments and documentation in both the syllabus and post-course on-the-job training. When mapping an individual course, we suggest using a template like the one shown in Table 8. Our broad competencies are: (1) data, (2) clients, (3) health systems, (4) epidemiology, (5) personal safety, and (6) outbreak response. Within each competency are topics to address, and colleges could add others within the broad categories if desired. Of note, we would not expect every cell of this table to be completed for an individual course. Rather, we save the evaluation of program completeness for step 2 of the three-step framework.

Table 8. Mapping Template for an Individual Course

Competency	Learning Approach		
	Didactic	Experiential	Practice-based
Data			
Software			
Analysis			
Collection			
HIPAA/Data Confidentiality			
Clients			
Contact Tracing			
Case Management			
Informed Practices			
Motivational Interviewing			
Health Education			
Professional Ethics			
Health Systems			
Connect to Resources			
Knowing Partner Roles in Public Health & Clinical Settings			
Epidemiology			
Determinants of Health			
Professional Health Literacy			
Disease Pathophysiology			
Personal Safety			
Potential Hostile Interactions			
Sample Collection & PPE			
Outbreak Response			
Health Alert Network			
After-Action Reporting			

HIPAA: Health Insurance and Portability Accountability Act, PPE: personal protective equipment

Within the template, mappers are encouraged to record ideas and opportunities for each of three learning approaches within each selected competency for a particular course. The three learning approaches are didactic, experiential, and practice-based, as described below. There are distinct benefits to using both didactic and active (i.e., experiential and practice-based) learning methods for health sciences students (Calabrese, 2023). Mapping for each competency might include exploration of both a didactic component and at least one type of active learning.

- **Didactic learning**, also known as “knowledge transfer,” is a way of transferring the base knowledge of a topic or skill to the student through traditional didactic teaching (lectures, videos, readings). This can be enhanced by a constructive learning approach that uses learner reflection on the content to make it more relevant to their experience.
- **Experiential learning** involves hands-on simulated practice (e.g., role-play, simulations, mock case evaluations), followed by a student’s reflection about the experience and how it might apply to future learning and employment. Experiential learning can include cooperative problem-based learning, where small teams solve a problem or complete a project using resources beyond those provided didactically.
- **Practice-based learning** applies the skills learned in coursework to a real-world setting through an internship, practicum, or community-engaged or service learning. When time and/or resources are limited, another option is role-play/simulation with professionals who use their real-world experience to give feedback to students on their skills development.

Step II. Identify curricular gaps

In this step, program developers map courses to the competencies of the complete curriculum (Table 9). The template is similar to that for course mapping but uses different column headers: column headers in the course map are the learning approaches, while column headers in the curriculum map are individual courses. At a minimum, the cells of this table would be completed with an X to identify where content is taught. This should allow visual assessment of whether all competencies are being covered. Course developers could also provide more detail, such as the learning approach and/or the learning activities. The additional detail shows whether different learning styles (e.g., visual, auditory, reading/writing, kinesthetic, but also logical, social and solitary) are being used to be inclusive of students’ strengths.

Review of the entire curriculum also allows program developers to determine if there is too much of one competency set and not enough of another. This can lead to adjustments in the way competencies are taught to enhance curriculum efficiency and coherence, as well as efforts to identify opportunities for scaffolded learning, in which early concepts are taught in one course and are reinforced with higher-level learning opportunities in a later course(s).

Table 9. Mapping Template for a Full DI Professional Program

Competency	Course to Which Competency(ies) are Mapped		
	[Course 1]	[Course 2]	[Course 3]
Data			
Software			
Analysis			
Collection			
HIPAA/Data Confidentiality			
Clients			
Contact Tracing			
Case Management			
Informed Practices			
Motivational Interviewing			
Health Education			
Professional Ethics			
Health Systems			
Connect to Resources			
Knowing Partner Roles in Public Health & Clinical Settings			
Epidemiology			
Determinants of Health			
Professional Health Literacy			
Disease Pathophysiology			
Personal Safety			
Potential Hostile Interactions			
Sample Collection & PPE			
Outbreak Response			
Health Alert Network			
After-Action Reporting			

HIPAA: Health Insurance and Portability Accountability Act, PPE: personal protective equipment

We acknowledge that the mapping process is iterative, moving back and forth between course mapping and program mapping. While this can take time, the enhanced efficiency and scaffolded learning can make for better student learning. It is not until the two mapping phases are complete that we recommend bringing the DI JTA into the mapping process. It is at this point that the detail contained within the DI JTA becomes accessible. The use of specific tasks at this point allows course developers to be specific in identifying what a student can do when the course is successfully completed. The DI JTA can also be used to identify what a student should be able to demonstrate through assignments. Many of the DI JTA tasks will require an assessment that relies on one of the active learning approaches (see experiential learning and practice-based learning above). For CCs that are incorporating DI professional programming into existing curriculum, this will likely require the modification of a number of assignments.

Step III. Evaluate the feasibility of adding new programming

The listening sessions confirmed enthusiasm for implementing DI professional training at CCs but also a recognition that adequate supports for students, staff, and faculty underpin the success of students and of the program. Here, we provide a series of questions and resource assessments that program developers can use to assess their readiness for adding a DI professional training program. Additional feasibility assessment

criteria may be needed to incorporate future national certification standards; however, this certification is under development and was not directly assessed in our project.

Program feasibility assessment. We based the listening session about feasibility on the work of Bowen et al. (2009). We adapted their feasibility criteria to ask specifically about implementing a DI professional training program (Table 10). Consideration of these questions—or similar questions relevant to the program—should help CCs determine their readiness to add DI professional training to existing curriculum or to create new programs. These questions can be part of the framework to guide program development and implementation.

Table 10. Proposed Questions to Address Feasibility of Implementing DI Professional Programming

To what extent would a DI professional training program...	Feasibility Domain (Bowen et al., 2009)	Curriculum Considerations
...be judged as suitable (satisfying, attractive) to your existing program(s)? To students?	Acceptability	- Define enrollment minimum and maximum numbers
...be used/accessed by students?	Demand	
...be able to be delivered as intended?	Implementation	- Describe what can be done with existing vs added resources - Consider potential disruptions to status quo - Project future growth
...be implemented using existing resources?	Practicality	
...require changes be made to existing infrastructure and processes?	Adaptation	
...be integrated within your existing educational system?	Integration	
...be expandable to new sites? (within or external to your system)	Expansion	- Global goal to serve local communities (include their input)
...show promise for increasing representation within DI professional workforce?	Limited efficacy	

Student support assessment. We based the listening session about student support on the work of Mantai & Dowling (2015). Built around three main types of support, program developers should survey the existing landscape to see what is available in each of these areas. This can include program- or major-specific resources, as well as those available across the entire CC sector. There may also be opportunities to reach out to employers and community organizations to identify additional supports that could help students, and the program as a whole, to succeed. Table 7 in this report provides resource suggestions to consider, based on the listening sessions with students, staff, and faculty. Also based on these conversations, below are some suggested questions to consider:

- Is synchronous or asynchronous course modality preferred? Are evening and weekend classes an option?
- Do academic advisors have adequate bandwidth to take on additional students? Do faculty have adequate bandwidth to mentor additional students? Are there opportunities for peer mentoring to supplement faculty mentoring?
- What types of financial aid are available? Will technical/instrumentation purchases be required for the DI professional program?
- What resources might non-traditional students need to participate (daycare, linguistic support, tutoring, transportation, etc.)?

Program developers may also want to consider conversations with their own students to add to this list

(see Appendix C for our student listening session question guide, as an example). One potential resource to consider from employer and community partners would be opportunities to offer practice-based learning experiences, as well as potential pathways to employment. This topic came up in different types of listening sessions, and was not specific to the student support discussion but could reasonably be part of the evaluation of supports for student success: (1) social support such as guiding/mentoring, and (2) instrumental support such as access to technical and instrumental resources at worksites, or financial resources that are associated with paid internships or pathways to employment.

- **Social support** includes emotional support, collegiality and companionship, as well as guiding and mentoring activities.
- **Academic support** includes access to conceptual, editorial, linguistic, and other academic resources.
- **Instrumental support** includes access to administrative and financial resources, as well as the availability of technical or instrumentation resources needed for training.

Challenges and Mitigation Strategies

Delayed Access to DI JTA and Impact on Project Timeline

The project began slowly due to delays in obtaining the DI Job Task Analysis (JTA), which was essential for initiating our course mapping and providing foundational information for our listening sessions. This setback postponed key activities, including the employer and faculty/staff listening sessions, which depended on the most recent JTA data. As a result, faculty/staff sessions were held during the summer, and the student sessions occurred in early fall, near the end of the project timeline.

To mitigate this, we collaborated closely with our partner colleges to ensure the sessions were scheduled in time to allow for transcription and coding of the findings. If we were to repeat this process, we would restructure the timeline to hold student listening sessions in late spring 2025, enabling participation from students with more course experience and improving the depth of feedback.

Limited Access to Course Materials for Mapping

Course mapping was complicated by the structure of online classroom management systems. Instructors stored assignment materials in platforms such as Canvas and Blackboard, which external team members could not access directly. Requesting individual assignment files from instructors proved burdensome and led to frustration.

To respect instructors' time and minimize disruption, we worked with the materials that were available and adjusted our mapping approach accordingly. While this limited the granularity of our analysis, it allowed us to maintain positive engagement with faculty participants.

Next Steps

We will share this report with interested CCs that were part of the data collection for this project. In particular, we have had discussions with SLCC staff about continuing this partnership to develop the DI professional training program at their institution. We have also discussed the possibility of SLCC developing a pathway to a bachelor's degree at the University of Utah. Similar conversations could be held with other CCs interested in developing this type of partnership.

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Employer Listening Session Guide

Welcome

Thank you for joining us today and participating in our listening session. My name is Lisa Gren and I am part of the Public Health Faculty at the University of Utah. I want to remind everyone about the informed consent cover letter you received previously. Remember you are welcome to leave the listening session at any time and choose not to participate. We ask that you respect the confidentiality of people participating in this listening session by not sharing any confidential information outside of this conversation. As we transcribe the listening session recording, we will keep your identities confidential.

Our Topic today is Disease Intervention (DI) employee readiness.

The results will be used to inform community colleges curriculum and to develop the services needed to guide students toward certification in disease intervention. This project is supported by Cooperative Agreement CK20-2003 from the Centers for Disease Control and Prevention (CDC) through an award to the Association of Schools and Programs of Public Health (ASPPH). The contents of this listening session do not necessarily represent the official views of the CDC and ASPPH.

Guidelines

Let's cover a few general guidelines:

1. We want YOU to do the talking.
2. We would like everyone to participate.
3. I may call on you if I haven't heard from you in a while.
4. There are no right or wrong answers, only differing points of view.
5. Everyone's experiences and opinions are important.
6. Speak up whether you agree or disagree.
7. We want to hear a wide range of opinions.
8. We are recording so try to speak one at a time.
9. We won't identify anyone by name in our report. You will remain anonymous.

10. We ask that you turn off your phones. If you cannot and if you must respond to a call, please exit the room as quietly as possible and rejoin us as quickly as you can.

My role as moderator will be to guide the discussion.

Opening Questions

Let's get started.

We will spend a few minutes introducing ourselves. (Show slide of name, organization, location, and recent book or movie you loved.)

What minimum knowledge and skills do you expect to see in a newly hired disease intervention (DI) professional?

- Are there any knowledge or skills that go beyond the minimum that you have particularly appreciated seeing in new DI professionals?
- How do knowledge and skills vary depending on the degree DI professional has attained?
- Should there be levels of certification and how would you differentiate the different levels based on skills?

What are your expectations for the on-the-job training you will need to provide when you hire DI professionals?

- Do you see this as essential for working in your organization or might it be part of the general training of a DI professional?
- Can you share any examples?

What has been one of your biggest frustrations with new DI professionals?

If you could create one required course for DI students, what would it be and why?

- What specific knowledge and skills would you expect to be part of that course?

What kind of changes are happening in your organization based on the current political environment that might affect your ability to hire and/or retain DIS?

Closing

We appreciate your time and all that you shared with us today. As a reminder everything that was said today stays between the group to ensure everyone's privacy.

Faculty/Staff Listening Session Guide

Welcome

Thank you for joining us today and participating in our listening session. My name is Lisa Gren and I am part of the Public Health Faculty at the University of Utah. I want to remind everyone about the informed consent you all received before joining today. Remember you are welcome to leave the listening session at any time and choose not to participate. We ask that you respect the confidentiality of people participating in this listening session by not sharing any confidential information outside of this conversation. As we transcribe the listening session recording, we will keep your identities confidential. Our topics today include feasibility of the Certified in Disease Intervention (CDI) coursework and any student support needed to complete the required coursework.

The results will be used to inform community colleges' curriculum and to develop the services needed to guide students toward certification in disease intervention. This project is supported by Cooperative Agreement CK20-2003 from the Centers for Disease Control and Prevention (CDC) through an award to the Association of Schools and Programs of Public Health (ASPPH). ASPPH has funded the National Board of Public Health Examiners (NBPHE) to serve as the CDI certification provider. The contents of this listening session do not necessarily represent the official views of the CDC and ASPPH.

Guidelines

1. We want YOU to do the talking.
2. We would like everyone to participate.
3. I may call on you if I haven't heard from you in a while.
4. There are no right or wrong answers, only differing points of view.
5. Everyone's experiences and opinions are important.
6. Speak up whether you agree or disagree.
7. We want to hear a wide range of opinions.
8. We are recording so try to speak one at a time.
9. We won't identify anyone by name in our report. You will remain anonymous.

10. We ask that you turn off your phones. If you cannot and if you must respond to a call, please exit the room as quietly as possible and rejoin us as quickly as you can.

My role as moderator will be to guide the discussion.

Opening Questions

Let's get started. We will be recording this session.

We will spend a few minutes introducing ourselves. (Show slide of name, organization, location, course you teach and name a student support resource that helped you through your schooling.)

Today we will cover two topics. First, we will explore the feasibility of coursework at the community college level that could lead to CDI certification. Second, we will discuss the status of student support at your institution.

We would like to discuss Bowen et al. (2009) guidelines for assessing the feasibility of a certificate of disease intervention at the community college level. Think about what a CDI program might look like at your institution when responding to the following questions:

- To what extent do you see a certification in disease intervention (DI) as suitable (satisfying, attractive) to educational programs? To students?
- Is there a mechanism to identify students who may be interested in DI work?
- To what extent can the certification coursework be integrated within an existing educational system?
- To what extent can the certification coursework be implemented using existing resources? To what extent does the certification coursework require changes to be made to existing infrastructure and processes?
- How would your institution go about mapping DI professional core competencies to undergraduate courses?
- How do students learn about and enter into different educational offerings?
- To what extent is the certification coursework able to be delivered as intended?
- To what extent can the certification coursework be expanded to new sites? (either within or external to the college's system)

Thank you for your participation for the first section of this listening session. Now let's switch gears and discuss student support resources.

- Tell me about the current completion rate of your programs.
- What can you tell me about the current community reach of your programs and how has this changed over the last several years?

There are three support categories we would like to learn more about (share slide for Mantai & Dowling, 2015):

11. Social: emotional, moral, guiding and mentoring, and companionship/ collegiality
12. Academic: editorial and linguistic, academic and conceptual
13. Instrumental: instrumental and technical, administrative support, financial support

Moderator: Spend a few minutes looking over this chart and let's discuss how your organization is providing these different types of supports and their effectiveness.

- What stands out to you as types of student support categories your organization is thriving in and share any examples you can think of?
- What stands out to you as areas your organization needs to improve in any of these areas?
- How well does your organization do at supporting broad engagement?
 - What are challenges you experience here?
 - What do you think the barriers are?
 - What successes have you had?
- If you could make any change to the current student support system, what would it be?

Closing

We appreciate your time and all that you shared with us today. As a reminder, everything that was said today stays between the group to ensure everyone's privacy.

STUDENT Listening Guide

Welcome

Thank you for joining us today and participating in our listening session. My name is Lisa Gren and I am part of the Public Health Faculty at the University of Utah. I want to remind everyone about the informed consent you received before joining today. Remember you are welcome to leave the listening session at any time and choose not to participate. Everything said today will remain confidential.

Our Topic today is students in Disease Intervention (DI) Program needs and barriers to success.

The results will be used to inform community colleges' curriculum and to develop the services needed to guide students toward certification in disease intervention. This project is supported by Cooperative Agreement CK20-2003 from the Centers for Disease Control and Prevention (CDC) through an award to the Association of Schools and Programs of Public Health (ASPPH). The contents of this listening session do not necessarily represent the official views of the CDC and ASPPH.

Guidelines

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4. There are no right or wrong answers, only differing points of view.
5. Everyone's experiences and opinions are important.
6. Speak up whether you agree or disagree.
7. We want to hear a wide range of opinions.
8. We are recording so try to speak one at a time.
9. We won't identify anyone by name in our report. You will remain anonymous.
10. We ask that you turn off your phones. If you cannot and if you must respond to a call, please exit the room as quietly as possible and rejoin us as quickly as you can.

My role as moderator will be to guide the discussion.

Opening Questions

Let's get started. We will begin recording this listening session.

Let's begin by having everyone introduce themselves, share what degree they are pursuing and describe a way they like to destress. For example, I'm Kristina, I'm studying Public Health and I like hiking as a way to destress.

- What factors did you consider when choosing your major?
- How have you gone about learning about different majors offered at your institution?
- What interests you in your field of study?
 - How did you first learn about it?
 - Why did it seem like a good choice to you?
- Have you considered withdrawing from the program (what barriers do you see to being able to complete your program?). What convinced you stay?
- What support do you receive from the school?
 - What has been helpful?
 - What has not been particularly helpful?
- What support do you wish you had received from the school?
- Is there anything else you want us to know about your decision to choose this degree/certification?
Or what it takes to continue through to graduation/certification?

Closing

We appreciate your time and all that you shared with us today. As a reminder everything that was said today stays between the group to ensure everyone's privacy. **Provide information about receiving the \$25 compensation.

