

**Report from the MCH Working Conference:**

**The Future of  
Maternal and Child Health Leadership Training**

**April 19-21, 2004  
University of Washington, Seattle**



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## ABSTRACT

In April 2004 a two-day *MCH Working Conference: The Future of Maternal and Child Health Leadership Training* was held in Seattle, organized by the Maternal and Child Public Health Leadership Training (MCH) Program of the University of Washington (UW) School of Public Health and Community Medicine, and the Center for Leadership Education in Pediatric Dentistry, UW School of Dentistry. The conference was funded by the Maternal and Child Health Bureau, UW Comprehensive Center for Oral Health Research and the Washington Dental Service Foundation. Approximately 120 participants attended; they represented 53 long-term leadership training programs, including 10 of the 11 program categories, funded by the Maternal and Child Health Bureau. The purpose of the conference was to define leadership in the MCH context, determine key leadership competencies and skills for trainees and faculty, identify curricula and training experiences to develop leadership, and consider methods to measure the process and outcomes of MCH leadership training. To our knowledge, this was the first national effort to convene leadership training programs from across the program categories to develop a framework for MCH leadership and leadership training. Two earlier leadership training workshops were held in 1987 and 1988, but participants were primarily Leadership Education in Neurodevelopmental Disabilities (LEND) program faculty and trainees.

Through plenary presentations and focused workgroup discussions, 11 cross-cutting leadership competencies were identified as essential for any MCH leader. In this report, we refine and categorize these into 4 primary or core competencies - communication skills, critical thinking, internal reflection, and ethics/professionalism - representing intrinsic capacities that should be present to some degree in all trainees at admission to leadership training (but which can be nurtured and reinforced during training); and 7 secondary competencies. The latter are complex applications that depend upon one or more primary competencies and require additional training (e.g., negotiation/conflict resolution, constituency building and policy/advocacy skills). The 11 competencies form a rough hierarchy of increasing complexity and inter-dependence on other competencies. Each competency is sub-divided into components of attitudes, knowledge and skills and intrinsic capacities. Both training experiences and outcome assessments can be matched to these component parts. A common recommendation of the workgroups was to utilize case-based training, experiential and real-life learning experiences as methods to develop leadership competencies. Major projects (such as capstone experiences) are suggested as a way to demonstrate and assess multiple competencies simultaneously. Long-term outcome assessment should reflect alignment with overall MCH Training Program goals and objectives.

Given the context of today's rapidly changing demographic, political and economic environment, we call for an approach to leadership training that focuses on *capability* – the ability to adapt and continuously improve. MCH competencies developed at this conference support a model of MCH leadership training that is beyond any single discipline or particular context, and that is close to this notion of capability. Hallmarks of leaders include interpersonal and communication skills and a moral commitment to MCH mission and goals. Based on all of these considerations, we propose a definition of MCH leadership that transcends disciplines and endures over time.

We recommend faculty development and continuing education (CE) opportunities for MCH field professionals, including content in MCH competencies of ethics/professionalism, internal reflection, management, negotiation and conflict-resolution; and in MCH history, policy and values.

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An *MCH Working Conference: The Future of Maternal and Child Health Leadership Training* was held in Seattle April 19-20, 2004. The Conference was supported by the Maternal and Child Health Bureau and the NIH-funded Comprehensive Center for Oral Health Research at the University of Washington (UW) School of Dentistry. Additional support was provided by the UW Department of Pediatric Dentistry and the Washington Dental Service Foundation.

The Conference was organized by the Maternal and Child Public Health Leadership Training Program of the UW School of Public Health and Community Medicine, and the Center for Leadership Education in Pediatric Dentistry in the UW School of Dentistry, in collaboration with the UW Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program, the UW Pediatric Pulmonary Center, the UW Teaching Scholars Program and the National Center for Education in Maternal and Child Health at Georgetown University.

Conference participants (more than 120 total) represented 10 of 11 MCHB-funded long-term leadership training program categories including 53 programs in 28 states (see Appendix for a list of MCHB-funded long-term leadership training program categories). Additional attendees included leadership trainees, interested faculty and public leaders from a variety of disciplines and backgrounds.

The conference co-chairs wish to express their appreciation to the funding agencies and entities and the many people whose support was critical for the success of this effort, including the conference speakers, panelists and work group facilitators; session chairs John F. McLaughlin, Greg Redding and Joel Berg; our tireless and cheerful project staff Carmen Velasquez and Cheryl Shaul, as well as Doug Schaad and Anne Foster for their help with the conference evaluation. We also wish to acknowledge the valuable input and help of the planning committee members, many of whom also served as work group facilitators, as indicated below. In addition, a number of participants from the 1987-1988 MCH Leadership Training Conference were able to attend to provide perspectives on the previous work in this area. We recognize the assistance of Jane Steffensen in developing work group instructions and reporting criteria. Finally we thank Ann Drum and Laura Kavanagh of the Maternal and Child Health Bureau for providing encouragement and important feedback at many key points in the planning process.

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## INTRODUCTION

**Purpose:** This conference began as an outreach activity of the University of Washington's (UW) MCH Center for Leadership Education in Pediatric Dentistry to create a national forum for an interdisciplinary discussion of leadership and leadership training. Collaborative discussion with the Maternal and Child Public Health Leadership Training Program at the School of Public Health and Community Medicine and other key partners at the UW led to the development of a larger vision for the conference: to engage interdisciplinary faculty from MCH leadership training programs nationwide in creating a conceptual framework for leadership and leadership training based on their cumulative experiences. With encouragement from MCHB we launched a national discussion. Four questions of vital importance to all MCH long-term leadership training programs were posed by MCHB:

- What is the definition of leadership in the MCH context?
- What are the key leadership domains, competencies and skills for trainees and for faculty?
- What are tools, curricula and experiences needed to develop leadership in training programs?
- What are the methods to measure process and outcomes of MCH leadership training?

**Conference Format:** These questions were explored in a series of key note addresses and panel discussions by MCH leaders from national, state and local arenas. In addition, intensive workgroup discussions explored the range and depth of leadership domains and competencies.

**Workgroup Assignments:** To help stimulate thinking about leadership competencies in advance of the conference, attendees were assigned to one of 12 workgroups, each addressing a different cross-cutting leadership competency. These leadership competencies were identified through discussion with planning committee members and review of other national work on leadership competencies. Participants were asked to bring to the conference one personal experience where the assigned competency was needed to complete a leadership task. From these shared stories, workgroups were asked to enumerate cross-cutting skills for any MCH leader practicing this competency, propose training experiences and suggest outcomes measures appropriate to evaluate this aspect of leadership training. Finally, workgroups were asked to define or further refine each competency, and to describe how a mature MCH leader might demonstrate this competency. Although few workgroups were able to complete all these tasks, the discussions that ensued were enormously rich and varied. (See Appendix for listing of workgroups and instructions).

**1987 – 1988 MCH Leadership Workshops:** Recommendations from two previous MCHB sponsored workshops on leadership training in LEND (Leadership Education in Neurodevelopmental and Related Disabilities) programs, held in 1987 and 1988, provided an initial frame for the 2004 conference. Additionally, several participants spoke on Day One to help set the context for the current meeting. The written reports from the earlier workshops along with other background information were made available to attendees on the 2004 conference Web site.<sup>1</sup>

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<sup>1</sup> Reports from the 1987-88 MCH Leadership Training Workshops available at: <http://depts.washington.edu/mchprog/leadershipconf/materials/1987conf rpt.pdf>

**Preparation of this report.** This report was prepared using a variety of sources, including transcripts from conference plenary sessions, verbal summaries from the different workgroups,<sup>2</sup> speakers' power-point presentations, and written summaries and notes from workgroups. Leadership competencies, as summarized in this report, were formulated after multiple passes through these materials to identify common themes and recommendations, as well as areas of overlap and redundancy. In describing each specific MCH leadership competency, we went beyond discussions of the work group assigned to that particular competency, and considered relevant deliberations in other workgroups, plenary sessions, and in some cases, the literature. From this synthesis, we propose an overall definition of MCH leadership. Because all workgroups could not fully explore training experiences and outcomes assessments for the competency areas in the time allotted, we consider training and outcome assessment in general terms and summarize recommendations for faculty development as well.

We have not attempted to present every aspect of leadership and leadership training discussed at the conference, rather we integrated and synthesized the material into an Executive Summary and Recommendations.

Finally, it should be noted that the views expressed here and the recommendations that follow are ours and have not received any official review or commendation from MCHB. All original competency summaries forwarded to us from the individual workgroups have been provided to MCHB for their review.

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<sup>2</sup> Video tape and transcripts are accessible at [http://www.cademedial.com/archives/MCHB/leadership2004/.](http://www.cademedial.com/archives/MCHB/leadership2004/)

## EXECUTIVE SUMMARY AND COMMENTARY

### MCH LEADERSHIP

**Importance of MCH leadership.** In a time of widespread and persistent health disparities for millions of US children and families, it is critical to identify, nurture and train the next generation of leaders to redress these inequities to the benefit of our collective future. MCH leaders carry the primary responsibility for maintaining national, state and local focus on the health of MCH populations. To be effective, MCH leaders require a broad array of skills and capacities that transcend clinical specialties or academic disciplines. As MCH leadership training enters the 21<sup>st</sup> Century, the competencies and the training experiences that can build and support MCH leaders are becoming more clearly defined. Likewise, outcome measures are being developed and tested. The purpose of this 2004 *MCH Working Conference: The Future of Maternal and Child Health Leadership Training* was to make a significant contribution to those efforts.

**Are MCH leaders born or made?** Like all adults, MCH leaders are the complex result of their intrinsic capacities and life experiences, including training opportunities. While we recognize that the developmental trajectories of individual MCH leaders are highly variable, it is possible, from a review of past efforts (including the 1987-1988 workshops), key literature<sup>3</sup> and the conference discussions, to identify cross-cutting themes and capacities important to MCH leadership and therefore germane to the training process. From this review we propose working definitions of MCH leadership and leadership competencies.

### ATTRIBUTES OF AN MCH LEADERSHIP

*An MCH leader is one who understands and supports MCH values, mission and goals with a sense of purpose and moral commitment. S/he values interdisciplinary collaboration and diversity, and brings the capacity to think critically about MCH issues at both the population and individual levels, to communicate and work with others and utilize self-reflection. The MCH leader demonstrates professionalism in attitudes and working habits, and possesses core knowledge of MCH populations and their needs. S/he continually seeks new knowledge and improvement of abilities and skills central to effective, evidence-based leadership. The MCH leader is also committed to sustaining an infrastructure to recruit, train and mentor future MCH leaders to assure the health and well-being of tomorrow's children and families. Finally, the MCH leader is responsive to the changing political, social, scientific and demographic context, and demonstrates the capability to change quickly and adapt in the face of emerging challenges and opportunities.*

### MCH LEADERSHIP COMPETENCIES

**Proposed MCH leadership competencies.** Twelve leadership competencies listed below were defined, discussed and debated over the course of this two-day meeting. These twelve originated with the conference planning committee following much discussion and review of national

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<sup>3</sup> Including the report *Assessment in MCH Training Programs* prepared for the Virginia Reed and distributed to attendees. <http://depts.washington.edu/mchprog/leadershipconf/materials/Reed-Dartmouth.pdf>

leadership competencies (including those of the Association of Teachers of Maternal and Child Health). Over the course of the conference, none of the proposed competences were dropped, nor were new competencies identified, although two were combined (Management skills and Working with Organizations). In synthesizing the conference output for these proceedings, we refined and grouped competencies into core (or primary) competencies and applied (or secondary) competencies. Core competencies reflect, to a significant degree, intrinsic capacities and traits - perhaps influenced by early experiences, and reinforced by later experiences and opportunities. Although they pre-date the MCH training experience, these intra-individual strengths (e.g., communication skills, critical thinking, self-reflection and ethics) can be encouraged and nurtured as part of the MCH training experience. We believe these competencies should be apparent at the time of entry into MCH programs, and this has implications for the selection of MCH trainees. Core competencies include:

1. Communication Skills
2. Critical Thinking
3. Internal Processes and Self reflection
4. Ethics and Professionalism (“a moral compass”)

Secondary competencies involve the application of core competencies to more complex situations and tasks faced by MCH leaders. Typically applied competencies require additional training. The teachable aspects of both types of competencies (core and applied) have implications for training programs and leadership curricula. The “applications” include:

5. Mentoring
6. Cultural Competency
7. Evidence Base and Science Translation
8. Negotiation and Conflict Resolution
9. Management Skills / Working with Organizations
10. Constituency Building
11. Policy and Advocacy

**Analysis of MCH competencies.** Following from workgroup discussions and conference interactions, we divided each competency into the following components: attitudes, knowledge, skills and intrinsic capacities; with the latter being especially important for the core competencies. We re-numbered the competencies, placing core competencies first followed by secondary applications that are ranked, approximately, according to increasing complexity of skills involved (Table 1 below). One page summaries of each competency start on page 20 of this report.

**MCH values.** The context for the conference and workgroup discussions was a set of shared MCH “values” reflected in the strategies proposed to achieve the five-year-goals of the MCHB Strategic Plan for 2003-7.<sup>4</sup> These include, among others, an emphasis on:

- scientific and evidence-based practices
- family-centered care

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<sup>4</sup> The MCHB Strategic plan can be found at <http://www.mchb.hrsa.gov/about/stratplan03-07.htm> , Accessed August 26, 2004

- culturally competent care
- community-based services and systems
- an interdisciplinary perspective
- a prevention orientation
- a population-based focus
- the priority of vulnerable populations
- recognition that, relative to adults, children have different health needs and requirements from personal and public health systems

Evidence-based approaches and cultural competency were addressed in specific workgroups. Other values were not further elaborated at the conference, although they are implicit in numerous references to the “MCH mission and goals.”

## **MCH LEADERSHIP TRAINING**

**Implications for training curricula and experiences.** Each work group was asked to identify training experiences that could teach or nurture the particular MCH competency. We have linked the different kinds of training experiences suggested to the component parts of the competency—i.e., the attitudes, knowledge, skills and intrinsic capacities – necessary for each leadership competency. Recommendations for skills-training typically included both didactic components and hands-on experiences, supported by mentoring activities and feedback to trainees. For example, at the simplest level, knowledge as information can be increased by didactic sessions, reading materials or Web-based resources, and most groups recommended some instruction along these lines. Work group participants recognized that influencing attitudes or beliefs is much more complex. Changes in attitudes and beliefs can be facilitated by 1) making underlying attitudes and beliefs explicit; 2) creating cognitive dissonance to stimulate self-awareness and change in attitudes; 3) providing trainees with specific feedback on attitudinal issues; 3) creating hands-on experiences (such as working with difficult-to-serve populations or talking with families about their health care experiences); 4) faculty modeling and mentoring; and 5) creating institutional congruency with important values/attitudes (i.e., aligning institutional structures in a way that cultural competency, for example, is a part of all administrative policies and processes).

The core competencies – communication skills, critical thinking, internal-reflection and ethics/professionalism – form the critical building blocks of most other competencies. Even though we believe these depend upon intrinsic capacities and should be apparent to some degree in MCH trainees at admission, we also believe that it is important to create a training culture and experiences that nurture and support these capacities and their exercise, refinement and application to real-life MCH setting. For example, training opportunities should be created to practice critical thinking, reinforce professional values, discuss important ethical issues and conflicts, encourage and provide time for internal reflection (journaling activities, retreats, etc), and provide feedback on trainees’ interpersonal skills.

**TABLE I: Cross-Cutting MCH Leadership Competencies**

Competency Name (Original conference workgroup number in parentheses)	Type: Core or Application
0. <sup>A</sup> <b>Historical and Legislative Context of MCH</b>	<b>Background</b>
1. <b>Communication Skills (1)</b>	<b>Core</b>
2. <b>Critical Thinking (11)</b>	<b>Core</b>
3. <b>Internal Process / Self-reflection (10)</b>	<b>Core</b>
4. <sup>B</sup> <b>Ethics / Professionalism (12)</b> a. Moral purpose (MCH mission/vision) b. Moral compass (professionalism) c. Ethical knowledge/skills	<b>Core</b> <b>Core</b> <b>Core</b> <b>Applied</b>
5. Mentoring (4)	Applied
6. Cultural Competency (3)	Applied
7. Evidence Base / Science Translation (6)	Applied
8. Negotiation / Conflict Resolution (5)	Applied
9/10 <sup>C</sup> Management Skills (8) & Working with Organizations (9)	Applied
11. Constituency Building (2)	Applied
12. Policy and Advocacy (7)	Applied

Table I outlines the original leadership competencies assigned to workgroups. These have now been grouped into 2 broad categories based on conference discussions and analysis. Core competencies are considered essential building blocks for all MCH leaders and include **communication skills, critical thinking skills, one’s internal process and ability for self-reflection, and ethics and professionalism**. Secondary competencies such as constituency building or advocacy are complex “applications” that build upon one or more primary, or core competencies, and require additional training. The core competencies reflect, in part, intrinsic capacities, which can be nurtured in supportive environments, but should be apparent, to a degree, in applicants. Other aspects of the core competencies can be modeled, practiced or taught during the training period. For example, while sensitivity in interpersonal communication may be an intrinsic capacity, skills for effective public speaking can be taught.

<sup>A</sup> Although this competency was not discussed at the conference, we feel all trainees and faculty should be exposed to MCH history, policy and values, including public-health and prevention-based approaches.

<sup>B</sup> Acquiring ethical knowledge is felt to be a secondary application; moral purpose and integrity are felt to be more intrinsic attributes.

<sup>C</sup> These were collapsed due to the similarities of topics covered and the lack of sufficient facilitators.

**Specific recommendations.** Some workgroups mentioned curricula that exist or could be adapted for MCH leadership training (e.g., negotiation and conflict resolution; cultural competency), while others identified gaps and the need to develop new curricula or apply others to the MCH setting (e.g., management skills, ethics/professionalism). Groups varied in the specific training experiences recommended, but some underlying themes could be identified. The general tendency was to recommend case-based training, story-telling, and experiential and real-life learning experiences for development of leadership competencies. This is consistent with an emerging trend to move beyond specific content to emphasize problem-solving skills and the capability to meet new challenges in the future (see Beyond Competencies, below).

We recognize the curricula of the training programs are already packed full and that developing additional leadership curricula and corresponding assessments to match all of the MCH competencies may not be possible. However, it might be possible to make greater use of program-specific “capstone” experiences in which students could develop and demonstrate learning in multiple competencies simultaneously. These are discussed further in the following section on Outcomes.

**Implications for candidate selection for MCH leadership training programs.** Although this conference did not specifically consider the question of how trainees are selected, the identification of important “core” intrinsic capacities suggests these should be sought in potential candidates, along with other program or discipline-specific criteria. The 1987-1988 workshops of LEND programs considered candidate selection in some detail. And while their conclusions will not be fully reiterated here, we note considerable agreement between competencies identified here as “core” and the 1987-1988 recommendations. In particular, the 1987-1988 reports identified “indicators of potential leadership” including: interpersonal and communication skills, self-motivation, flexible and adaptable thinking and temperament, and maturation. These are similar to many capacities and characteristics highlighted in the competency summaries below. The 1987-1988 report also reminds us that a strong predictor of future leadership is past achievement, calling attention to applicants who have done “more than expected, sooner than expected.” Additional work is needed to develop methods to assess core qualities in applicants and evaluate the usefulness of selection criteria based on these qualities.

**Implications for faculty development.** The training agenda that might emerge from the proposed MCH competencies has obvious implications for faculty development and many groups discussed the need for faculty training. Below we identify a number of areas for future faculty development efforts.

**1. Educational methods:** While there are many experienced faculty across MCH programs, few faculty in the health professions have had the benefit of formal training in educational methods. Although many universities offer educational classes for faculty, most training programs exist in systems that prioritize research and publications for promotion, and it may be difficult for faculty to allocate time to educational courses. There may be value in a toolkit (Web based) to guide development of seminar and small-group discussion groups, learning objectives, outcome assessment, etc., adapted to the MCH context. At the very least, such a resource could greatly accelerate the process of new faculty acquiring the skills to be effective educators. Beyond traditional methodologies, faculty may wish to acquire additional expertise in “active learning” methods to further enhance learning. These might include using voiced in video-taping to debrief

cases, patient interviews, focus groups or presentations. The goal of these experiences is to make the implicit explicit, and to make optimal use of “teachable” moments.

**2. Mentoring component:** Mentoring is specific kind of educational competency. It develops with experience, maturity and self-reflection. Opportunities for specific faculty development in this area could enhance MCH capacity to move trainees forward to leadership success.

**3. MCH leadership competencies:** Specific competencies could be targeted for faculty development, possibly with Web-based curricula (e.g., negotiation and conflict resolution, management skills in the MCH context, internal reflection, ethics/professionalism). We realize few MCH trainees or faculty will have equal strengths in all core competencies or applications, but we believe all should have an understanding of the importance of all these skills, and know when and where to seek additional resources when challenged beyond their abilities in these areas.

**4. MCH background and history:** Although not discussed at the conference explicitly, we feel all trainees and faculty, regardless of their discipline, should be exposed to MCH history, policy, responsibilities and values, including public-health and prevention-based approaches. This could be offered via Web-based modules or on campuses where such resources already exist.

**5. New training models for faculty:** Beyond the traditional and technology-supported educational methods, new models of education that move beyond *competency* to *capability*, discussed below, will require additional faculty development.

**Beyond competencies to capability: MCH Leadership as a moving target.** One of the greatest challenges to leadership education is that we must train leaders today to function in a future we can not know. Rapidly advancing science and technologies, shifting demographics, and global political, economic and social forces will only accelerate changes in the MCH environment. The 1987-1988 MCH workshop participants humbly acknowledged, as do we, our limited ability to predict future threats and opportunities. This hampers our ability to devise curricula for tomorrow’s challenges. There is wisdom in a recently articulated trend to extend training beyond competence (defined as knowledge, attitudes and skills) to capability (defined as “the individual’s ability to adapt to change, generate new knowledge, and continue to improve their performance”).<sup>5</sup> We believe the construct of capability may be closer to the needs of future MCH leaders than traditional evaluation targets.

Despite our use of the traditional term “competency,” we believe that, when considered as a set, the MCH leadership competencies formulated at this conference actually encompass (and even extend) the notion of *capability*. To begin, the MCH leadership competencies reflect *cross-cutting skills* that are not content or context specific, but applicable to a wide range of settings, problems and disciplines. Second, they include *critical thinking skills*, such as analysis and problem-solving as well as synthesis / integration of information. Third, there is a focus on *evidence-base / science translation*, which addresses the need for constant acquisition of new

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<sup>5</sup> Fraser SW, Greenhalgh. Coping with complexity: educating for capability. BMJ Oct 6, 2001, 323, 7316, p799 ProQuest Medical Library bmj.com

knowledge and skills by MCH leaders. These cross-cutting competencies address many of the cognitive aspects of capability, as well as the attitudes that support their use.

The MCH leadership competencies also reflect humanistic and moral attributes needed by future leaders. For example, the core competencies of *communication skills* and *internal reflection*, and certain applications, such as *cultural competency*, *negotiation/ conflict resolution*, and *constituency-building*, are qualities of human interactions. Interpersonal skills will always play a key role in individual health education and health policy choices, and are important for moving any MCH agenda forward. Our inter-dependence and need for collaboration to achieve MCH goals are even more apparent in a complex, global environment. A personal moral compass and strong commitment to MCH mission and values (*ethics/professionalism*), along with the support of the larger MCH community, will help the MCH leader of the future react rapidly to new challenges with compassion and a strong moral bearing. These constructs also have implications for the development of outcome measures.

## OUTCOME MEASURES

### Outcome Measures: Programs, Processes and Individuals

One perspective on outcome evaluation is to view the MCHB Long-Term Training Program and its products as a set of inter-related structures across several levels, each with separate yet compatible goals and objectives. At the over-arching level is the training program itself, and contained within are the training program categories, individual programs, trainees and graduates. Peak performance in business, education and health care settings is a consequence, in part, of a transparent process to achieve a clearly articulated mission. Among many important issues discussed at this conference was the value of aligning evaluation criteria with MCHB's vision and mission, and the tension that arises in doing so when MCHB's expectations of the long-term training programs (e.g., for technical assistance and other forms of professional service) differ from universities' and clinical training sites' requirements of faculty and trainees.

Nonetheless, training program activities and products should be aligned with the intent and aim of the bureau. A new vision and National Plan for MCH Training 2005 - 2010 with goals, strategies and objectives was drafted recently. This, in addition to the overall mission, vision and goals reflected in the bureau's 2003 - 2007 strategic plan<sup>4</sup>, provides an excellent starting point for evaluation criteria. Following from those statements, for the first time the Progress Report Guidance of FY 2004 asked all training programs to report on a set of uniform performance measures. The measures were relatively general, and necessarily so, to be relevant to the range of content, setting and duration within and across the training program categories. Ongoing and future work will continue to identify and refine process and outcome indicators of each level of the training program's impact on the health and well being of our nation's children and families

**National program level outcomes.** At the national level, goals and objectives for the MCHB Long-Term Training Program include training to all levels of the MCH pyramid: infrastructure, population-based services, enabling services and leadership in interdisciplinary clinical settings in order to support local, state and national MCH priorities. The diversity in training "products" to meet these needs is reflected in MCHB's MCH Training Performance Measure # 08, which defines leadership in terms of long-term trainees' achievements in academic teaching, research, technical assistance, clinical services, public policy and advocacy. Beginning with the 2004

progress reports, all training programs will report annually on this measure of field leadership among their long-term trainees five years after graduation.

**Individual program level outcomes.** At the individual program level, indications of success might include expansion of the infrastructures and processes to accomplish MCH leadership training (e.g., training opportunities that connect co-located programs of different leadership training categories), continuous improvement in depth and capacity of training experiences offered, and the provision of continuing education and training for graduates and the larger regional and national network of MCH professionals. While this conference did not address continuing education directly, the need follows clearly from faculty development goals discussed previously in this report.

**Trainee outcomes.** At the individual level, a universal indicator of long-term success would be the graduation of professionals with an abiding commitment to the MCH vision. We expect our trainees will eventually be able to assume leadership roles in various settings including local, state or federal governments, private sector and not-for-profit clinical service agencies, with grant makers, in academia, and in a variety of roles (i.e., scholar, teacher, clinician-researcher, advocate, policy maker, administrator). As noted, the MCH Training Performance Measure #08 captures this diversity of expectations in leadership outcomes.

Indicators of leadership upon graduation from the training programs would be more varied, necessarily, to reflect differences in career trajectories and in the developmental stage of each trainee. The “developmental” nature of leadership ability identified at the previous MCH leadership conferences in 1987 and 1988 and discussed throughout this 2004 conference conceptualizes growth in leadership as moving along a trajectory of increasing expertise and responsibility. Accordingly, expectations and signs of leadership differ for mature versus relatively new leaders. It follows that evaluation of trainees’ successes during and upon graduation should be tailored both to their career goals and stages of leadership development.

**Assessing outcomes by tracking leaders over time.** Currently MCHB requests that programs track long-term trainees to provide feedback on field leadership in “academics, clinical, public health / public policy and advocacy” (MCH Training Performance Measure #08). Publications, research accomplishments and participation in national and local public and clinical organizations, task forces and boards are reviewed as part of this performance measure. Conference participants’ discussion of outcome measures supported these as among the most common and desired products of leadership training.

**Assessing individual leadership competencies.** Linking outcome evaluation with the competency framework would assess an individual’s acquired knowledge, attitudes, skills and intrinsic capacities in each of the MCH leadership competencies. Change in knowledge is perhaps easiest to measure, but differences in attitudes can be obtained also, through for example, self-assessment. Additionally, faculty observations and consumer (e.g., family or patient) feedback can provide important information on attitudes and core competencies such as interpersonal and communication skills. Individual journaling by trainees and discussions with mentors might be helpful for goal setting and to assess professional development and internal reflection. More complex, applied competencies (e.g., science translation, constituency building, policy and advocacy) can be demonstrated in numerous ways including scholarly papers, presentations, research and community projects. Other specific practice-oriented skills can be

taught and demonstrated directly. Examples of skills taught within some training programs represented at the conference include: grant writing, development of a strategic plan, running meetings and case conferences, assisting with policy development, and evaluating and revising health education materials and practices to ensure culturally-competent, family-centered messages and procedures.

**Assessing capability along with competence.** As discussed above, to meet new challenges in ever-changing societal contexts, MCH leadership for the future will require competence and “capability.”<sup>6</sup> An educational environment suited to develop both competence and capability must draw on multiple learning methods. While traditional assessments of competency (e.g., exams to test knowledge or observations of behavior in practice settings) ask for the demonstration of familiar skills in familiar settings, demonstrations of capability focus on the process of solving somewhat unfamiliar problems in unfamiliar environments.<sup>7</sup>

Developing leadership curricula and assessments in addition to those needed for discipline-specific competencies can be a daunting task. However, it seems possible to make greater use of capstone experiences to the benefit of both leadership and discipline-specific goals. Capstone projects refer to “culminating experiences in which students synthesize subject-matter knowledge they have acquired, integrate cross-disciplinary knowledge, and connect theory and application in preparation for entry into a career.”<sup>8</sup> Capstone experiences could include practica, thesis research or other field- or clinic-based projects depending on the discipline and context.<sup>9</sup> The hierarchy of MCH leadership competencies presented in this report suggests one approach to capstone experiences for leadership trainees. Since more complex leadership competencies (e.g., evidence base/science translation, constituency building and policy/advocacy) depend upon mastery of other competencies (e.g., communication skills, critical thinking, negotiation), as presented in Table I, one could create a capstone experience that would allow the trainee to practice and demonstrate multiple competencies simultaneously within a single project.

Integrative capstone experiences that call together multiple, relevant leadership and discipline-specific competencies to address relatively novel, concrete tasks could be created for each training program category (e.g., public health, nursing, LEND, pediatric dentistry, pediatric pulmonary programs). The thesis research of the MPH is perhaps the most full-blown example; examples within clinical programs might include creating an adolescent health education

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<sup>6</sup> Capability – extent to which individuals can adapt to change, generate new knowledge and continue to improve their performance. Fraser SW & Greenhalgh T. Coping with complexity: Educating for capability. *British Medical Journal* 2001;323:799-803.

<sup>7</sup> Measures that address the individual’s ability to apply skills to untested situations are difficult to design. Well-known examples include the NASA space travel simulations and advanced, hands-on leadership workshops offered to business executives. The medical professional is moving towards the use of standardized patients to assess aspects of care that may be difficult to quantify, including communication skills.

<sup>8</sup> Kerka, S. (2001). Capstone experiences in career and technical education. Practice Application Brief No. 16, ERIC Publications. Referenced in <http://www.provost.cmich.edu/assessment/toolkit/capstone.htm> September 2, 2004

<sup>9</sup>Using Capstone Experiences in Student Learning and Assessment, Central Michigan University. Accessed August 16, 2004

curriculum to encourage exercise and healthy eating (LEAH), evaluating new policies affecting children with special healthcare needs (LEND) or designing and testing patient education materials to teach parents about the oral health care needs of infants and toddlers (pediatric dentistry). The expectations of the capstone experience could be determined within each long-term training program category and possibly become a category-specific performance measure by graduation. Indeed, many training programs already include projects that could be re-cast for this purpose. In some cases, it might be possible to link the capstone projects to the priorities and needs of the region's Title V agencies. This would have an added benefit of strengthening the link between the MCHB Training Program and the MCHB Block Grant Program.

**Collaboration and partnership as a leadership training outcome.** At this conference, Dr. Virginia Reed presented an analysis of leadership narratives of faculty and graduates that were included with the 2003 MCH Leadership Training Program Progress Reports. Dr. Reed found, for the most part, the narratives reflected the criteria specified in Performance Measure #08.<sup>3</sup> An interesting exception was that "collaboration" was used frequently to describe leadership activities, but "collaboration" does not map to Performance Measure #08 easily. As she pointed out, the ability to work collaboratively is necessary for MCH professionals because of the interdisciplinary nature of MCH work. Conference workgroups also discussed collaboration, although more often as a process than as a product of the leadership training.

"Partnership" is a term that describes one outcome of successful collaboration (although collaboration does not necessarily lead to enduring partnerships). The MCHB Strategic Plan FY 2003-2007<sup>3</sup> includes partnerships (i.e., "forge strong, collaborative, sustainable MCH partnerships both within and beyond the health sector") as a key strategy to achieve Goal 1: Provide National Leadership for Maternal and Child Health. Currently, information about partnerships is reported on the progress reports in the context of technical assistance. Dr. Reed and the conference discussion remind us that MCH partnerships are a valuable outcome of the long-term training program.

## CONCEPTUAL FRAMEWORK

### The Role of Training in the Trajectory of MCH Leadership

The conference materials and ensuing conversations lead us to articulate a simple conceptual framework for MCH leadership and leadership training that is cross-disciplinary and leads to testable hypotheses. The framework begins with intrinsic capacities that should be present in trainees at admission to the training programs, regardless of program discipline. At a minimum, these should include: communication skills, critical thinking skills, capacity for internal reflection and a sense of ethics and professionalism. After a student is admitted to the training program, these intrinsic competencies can be nurtured and focused on the MCH context, along with discipline-specific training. More complex leadership competencies would be cultivated within the training programs also, at a depth and level appropriate to the program category and individual trainee's goals. Complex leadership skills draw on the core competencies in an approximately hierarchical relationship. For example, it is hard to be an effective coalition-builder without excellent communication skills, the ability to negotiate across multiple constituencies and manage a change process. After graduation, we expect these skills will be honed further in the crucible of real-world experiences. Ideally there is continuity between the training program and its graduates (via surveys, alumni visits/guest lectures, CE, etc.) to provide

training programs with feedback needed to modify curricula in a continuous quality improvement model.

### **Alumni Surveys**

At the conference some faculty mentioned their programs had alumni surveys in place for many years. Now, all programs will conduct alumni surveys as part of the long-term trainee survey required for Performance Measure #08. One could use the opportunity of the alumni survey in a number of additional ways: to track career development (possible defined in a way that would allow us to capture MCH “partnerships” created by our trainees within and beyond the health sector), trace the development of newly-formulated leadership competencies (e.g., in ethics or negotiation) and the emergence of others. This source of continuous feedback could be used to maintain the relevancy of the training programs to the ever-changing demands of MCH practice. Close alignment between the training programs and MCH field leaders (Title V and other agencies and institutions) is mutually beneficial to the MCH work force and the training programs themselves.

### **RECOMMENDATIONS**

Our recommendations are to seek additional feedback on this work; increase capacity of MCH leadership training programs by developing new curricula in cross-cutting MCH leadership competencies and disseminate existing expertise; increase networking across programs and disciplines and with MCH field professionals; and continue to develop appropriate outcome measures and performance indicators consistent with MCH mission and goals.

Specifically, we recommend:

1. **Seek feedback** on the proposed definition of MCH leadership and competencies from:
  - a. Faculty of MCHB Long-Term Training Programs not present at the Seattle conference
  - b. Long-Term Training Program Categories (as a group)
  - c. Trainees and graduates of MCHB Long-Term Training Programs
  - d. Families and patients served by the Training Programs
  - e. Title V programs
  - f. Other MCH stakeholders nationally
2. **Re-visit conference outcomes** in October 2004 at the national meeting of all MCHB grantees (see Addendum below)
3. **Develop a plan for faculty development to increase leadership training capacity:**
  - a. Develop 2-3 new Continuing Education (CE) opportunities per year for MCH Long-Term Training Program faculty, by contract or competitive applications, based on the MCH leadership competencies identified at this conference and refined further. Target CE where gaps have been identified and new curricula must be developed, i.e.,
    - i. Ethics and professionalism
    - ii. Negotiation and conflict resolution
    - iii. Management and working with organizations

- iv. MCH history, policy and public health approach
  - b. Draw on existing training materials (e.g., negotiation and conflict resolution from the fields of business or law) and adapt the materials to the MCH context
  - c. Design CE faculty workshops to increase cross-disciplinary and cross-program networking
  - d. Consider using Web-based, distance-learning training technology to support distribution of CE training to a broader audience of MCH faculty and the MCH workforce
  - e. Encourage programs to choose 1 or more leadership competency areas for additional faculty development each year
4. **Build on the existing MCH Leadership Institute** for MCH field professionals. Where appropriate, consider linking this with faculty development activities. A benefit of this will be enhanced networking, but potentially also a fruitful discussion of the intersection of real-life MCH field skills needed and educational priorities of leadership training programs.
  5. **Consider capstone experiences** to demonstrate multi-dimensional leadership training outcomes within each program category. Given there are multiple leadership competencies (recall Table I) which overlap, capstone experiences could be created in which to practice and evaluate multiple competencies simultaneously (e.g., research reports or presentations, field activities to demonstrate the role of cultural competency in constituency building).
  6. **Continue to work toward realistic, feasible, measurable outcomes** that are aligned with MCHB mission for the training program and ensure an on-going source of MCH leaders.
  7. **Re-institute previous linkages between the long-term training programs, state Title V and HRSA field offices** to create and sustain active and reciprocal partnerships for training and technical assistance.

## ADDENDUM

The findings of the Seattle conference were presented to a group of MCH Long-Term Leadership Training Program directors and their representatives at the MCHB all grantee meeting, “The Power of Partnership,” held in Washington, DC, October 3-6, 2004. During this meeting a leadership competencies workgroup was convened to consider this executive summary and the MCH leadership competencies.

General results of the discussion include the following:

- 1) There was broad agreement that the MCH leadership competencies and conceptual approach as outlined provide a useful framework for future work
- 2) There was support for the notion of cross-cutting core competencies, which trainees must evidence to some degree at admission, although which require both nurturing and additional instruction within leadership training programs
- 3) There was support for the notion of cross-cutting competencies (applications) which depend to some extent upon each other in the hierarchy suggested, and which require additional specialized training
- 4) In addition, the notion of disciplinary expertise and competency was emphasized
- 5) Suggestions were made to break out the management / working with organizations competency into two separate areas, and to flesh out a one page description of what would be included in a “Module 0” of basic MCH information (Jonathan Kotch will do)
- 6) There was general appreciation of the tension between competencies we define today and the uncertainty of future needs, and the need to think more of capability – which includes life-long learning and adaptability to the changing MCH context
- 7) The point was re-iterated that while no MCH leader will have proficiency in all the competency areas, it is important that *someone* on the team has expertise in a particular area.
- 8) There was a suggestion to re-frame the definition of a MCH leader to include a list of attributes with bulleted actions and behaviors that advance MCH values and goals
- 9) There was discussion of the definition of “to lead” – which includes activities of MCH professionals regardless of their official designation of authority.
- 10) Although there was discussion of both MCH competencies and MCH leadership competencies, no striking and distinct differences were highlighted. The question was raised as to whether there was a quantitative rather than qualitative difference (ie, level of proficiency in competency areas).
- 11) There was discussion of the developmental trajectory of leaders, which varies depending upon training program category, level of training, discipline, background skills and individual characteristics. Outcomes should consider this developmental trajectory.
- 12) Finally there was discussion of the “value-added” of MCH leadership training. The following points were made:
  - a. Real world interdisciplinary experience – including learning as a team
  - b. Life-span, developmental approach embedded (from reproductive health, infant and child health, adolescent, maternal and family health)
  - c. Public-health and population-based orientation: ability to move from the individual level to the population level and back again
  - d. Definite focus on vulnerable MCH populations – those with highest disparities (children), CSHCN, etc

- e. A strong national infrastructure supporting research, training, outreach and all of the collaborative activities to improve the health of MCH populations
- f. The long-term training program assures a large network of MCH professionals who are always considering the impact of policies, environmental and other threats and opportunities for MCH populations
- g. Investment, through children and families, in adult health of the future

Recommended next steps:

1. Reframe definition of MCH leader as “attributes of MCH leader”
2. Separate competency defined as “working with organizations” from “management”
3. “Module 0: MCH Background information for interdisciplinary trainees”
4. Some type of self-assessment of programs as to their expertise and need for faculty development in the various competency areas
5. Begin development of educational resources in some key gap areas, such as MCH background information, ethics, negotiation and conflict resolution, management and working with organizations
6. Consider other f/u in the form of white papers, conference calls, meetings, etc., as needed to move this agenda forward

## Working Definitions of MCH Leadership Competencies

### 1. COMMUNICATION SKILLS (core)

*An MCH leader practicing this competency can communicate with multiple audiences using multiple modalities. This competency engages both emotional and intellectual capacities, and includes non-verbal, oral and written skills. The MCH leader draws on these capacities and skills to develop and maintain collaborative relationships, to communicate information effectively and to inspire others to accomplish MCH goals.*

**Intrinsic capacities** important for this competency are empathy and the ability to establish rapport and trust. To these ends, the MCH leader must be sensitive to the cues of self and others (these are described in the core leadership competency “internal process / self reflection”). Verbal abilities and fluency support this competency; critical thinking is necessary to construct a logical and convincing line of argument. MCH leaders with charisma utilize their own personalities and moral passion to attract others to the MCH mission and goals.

**Attitudes:** In order to inspire others, the MCH leader must communicate a sense of the moral importance of MCH mission and goals, along with a belief that change for the better is possible. The MCH leader respects and values input of others, appreciates the necessity of multiple perspectives, and realizes the importance of building and sustaining relationships to accomplish MCH goals. The MCH leader is willing to share himself, or herself, as appropriate, to the professional context and tasks, but maintains good boundaries for self and others.

**Knowledge:** The MCH leader needs to understand basic principles of strategic communication and framing, and how to identify an audience’s needs and assess readiness for change in patients, colleagues and other constituencies. Principles of adult learning are also relevant to this domain.

**Skills:** The goal is development of collaborative relationships and effective transfer of information in tasks related to the MCH mission. Measurable skills include:

- Demonstrates respectful listening and sensitivity in interpersonal interactions
- Frames information with audience in mind
- Makes good use of oral, written and email communications (etiquette, form and content)
- Can tell a story: develops a clear, convincing line of argument to support a particular point of view and convey the important issues at stake

## 2. CRITICAL THINKING (core)

Critical thinking has been defined as the disciplined mental activity of evaluating arguments or propositions and making judgments that can guide the development of beliefs and action steps.<sup>10</sup>

*An MCH leader practicing this competency should be able to define with precision an issue, the assumptions upon which it is based, and the context in which it emerges. The MCH leader must be objective and receptive to various viewpoints, and able to justify views based on data and logic as well as values, perspectives and assumptions of oneself and others. The MCH leader utilizes critical thinking skills in order to understand and at times persuade others about beliefs, viewpoints, and rationales for decisions and actions.*

**Intrinsic capacities:** Critical thinking requires the intellectual capacity to understand information and carry out rational deliberation and meta-cognition to identify one's own habits of thinking. Critical thinking involves symbolic manipulation of information using language, visual and/or mathematical mechanisms. In applying critical thinking, the MCH leader utilizes self-reflection to understand his/her own values, and empathy to understand others and the basis for their beliefs. Other characteristics that support the use of this competency are curiosity to seek new information and viewpoints; and flexibility to accommodate new information, as it emerges, that might alter beliefs and conclusions.

**Attitudes:** The MCH leader must be committed to intellectual honesty and possess humility in order to challenge himself or herself and listen to input from others. The MCH leader must be comfortable with being wrong, assessing why and revising conclusions based on new and different information. S/he must be fair and objective in assigning value to data and beliefs that impact an argument or course of action. Finally, the MCH leader must appreciate the importance of critical thinking and be willing to take the time to apply these skills.

**Knowledge:** The MCH leader must appreciate the complexities of beliefs that exist among individuals, organizations and societies, and their influence on how issues are framed and addressed. The MCH leader may also benefit from a review of research and ideas about critical thinking. Critical thinking skills are placed in a cognitive hierarchy of increasing complexity and difficulty – knowledge, comprehension, application, analysis, synthesis and evaluation.<sup>11</sup> Evaluation focuses on making an assessment or judgment based on an analysis of a statement or proposition. Synthesis draws on creative thinking to look at parts and relationships (analysis) and put these together in a new and original way.<sup>12</sup>

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<sup>10</sup> Huitt, W (1998). Critical thinking: An overview. *Educational Psychology Interactive*. Valdosta, GA: Valdosta State University. <http://chiron.valdosta.edu/whuitt/col/cogsys/critthnk.html> Accessed August 13, 2004.

<sup>11</sup> Bloom, B., Englehart, M., Furst, E., Hill, W., & Krathwohl, D. (1956). Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive Domain. New York: Longmans Green.

<sup>12</sup> Scriven, M., & Paul, R. (1992, November). Critical thinking is the “the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication, as a guide to belief and action.” *Critical thinking defined*. Handout given at Critical Thinking Conference, Atlanta, GA. <http://chiron.valdosta.edu/whuitt/col/cogsys/critthnk.html> Accessed August 13, 2004

**Skills:** Some skills to improve and conduct critical thinking include the following:

- Pose a clear and precise question
- Identify assumptions and detect ambiguities
- Use credible sources of information
- Remain relevant to an issue
- Look for alternatives
- Withhold judgment
- Deal with parts of a complex whole
- Develop criteria for an answer
- Analyze arguments, including deductions and inductions, and come to conclusions

### 3. INTERNAL PROCESS / SELF-REFLECTION (core)

*An MCH leader cultivates and practices habits of honest self-reflection essential to effective leadership. S/he understands his or her own leadership trajectory and growing edges, the strengths and limitations of his or her personal leadership style. S/he strives for resilience, learning from successes and failures, regularly seeks and integrates feedback from others. S/he can identify and meet needs for self-renewal, support and mentoring. The MCH leader knows his / her own moral compass and exercises honest self-monitoring. This self-reflective practice brings congruence between the MCH leader's inner source of strength and energy and his/her actions as an MCH leader – creating a sense of transparency of purpose, motivation and commitment to the MCH mission and values.*

**Intrinsic capacities:** The capacity for self-reflection and insight involves sensitivity to one's internal responses (feelings) and habits of thinking, and awareness of and respect for these processes in others. Characteristics that support this capacity include openness, flexibility, patience, calmness, humility, honesty, courage and curiosity. This competency is supported also by the other core competencies of critical thinking, communication skills and ethics / professionalism.

**Attitudes:** The MCH leader believes in self-reflection as a tool for deepening commitment, understanding actions and maximizing personal satisfaction. S/he has the maturity and curiosity for self-reflection, self-evaluation and benefiting from feedback from others. S/he respects her own and others' boundaries, recognizes her own position on issues, and is non-judgmental towards others who are different. She/he can differentiate motivation for personal advancement from that for the greater good, and strives for a realistic balance that respects both motives. S/he appreciates both the potential and limitations of her contribution to the MCH mission.

**Knowledge:** The MCH leader cultivates self-knowledge and also makes use of the professional development literature, for example, on leadership styles and the strengths and weaknesses of different approaches. S/he understands the importance of appropriate boundaries in relationships, and how to recognize and remedy, in a professional manner, difficulties with interpersonal boundaries. S/he knows and can recognize the signs of burn-out in self and others. Other areas of self-knowledge include personal and professional goals, underlying motives and aspirations

**Skills:**

- S/he re-visits her professional role periodically to assess alignment of professional activities with long-term career and personal goals
- Open and responsive to the environment while maintaining progress towards long term goals
- Proactively addresses moral difficulties; seeks help if needed.
- Maintains appropriate boundaries with others
- Strives to match strengths and weaknesses to work roles and opportunities
- Learns from successes and failures; seeks out, integrates feedback from others; uses mentors
- Identifies and meets needs for personal and professional renewal
- Can prioritize among choices and activities
- Recognizes own leadership style and its strengths and weaknesses, and finds ways to compensate for them, seeking collaborators whose competencies complement her own

#### 4. ETHICS AND PROFESSIONALISM (core)

*The MCH leader has a deep moral commitment to improving the health of MCH populations. S/he recognizes the extent of health disparities in the U.S. and seeks to redress these inequities for all underserved and vulnerable populations regardless of race, color, creed, socioeconomic status or community of origin. The MCH leader demonstrates professionalism and high personal integrity. S/he is knowledgeable about the basic ethical and legal dimensions of clinical care, biomedical research, public policy, and teaching / mentoring. The MCH leader is sensitive to ethical dilemmas in these arenas and approaches them with empathy and moral courage, applying appropriate models of ethical decision-making or referring for appropriate consultation as needed.*

**Intrinsic capacities:** Although the origin and development of basic human moral principles (the golden rule, not harming or stealing from others, etc.) has been the subject of intense psychological, philosophical and theological study, it is not clear to what extent these values are innate, subject to early experiences or culturally determined. However these develop, by adulthood most individuals have some intrinsic moral codes that guide their actions. In the case of MCH trainees, the desire to help MCH populations should be part of their internal make-up. Self-reflection may be important to retaining personal integrity and maintaining a moral compass. At a more practical level, the practice of ethical decision-making is greatly enhanced by good interpersonal skills, empathy and critical thinking.

**Attitudes** that support professionalism and ethics include respecting others' dignity and rights, valuing the input of others, being non-judgmental of others with differing beliefs and believing that ends do not justify means. Other important attitudes include comfort with ambiguity and the belief that health professionals should consider the health of the public as well as that of individual patients.

#### **Knowledge:**

- Ethical and legal dimensions of
  - clinical care: decision-making for children, informed consent; professional-patient relationships and interactions
  - biomedical research: protection of human subjects and personal information, informed consent; ethics of research in vulnerable populations
  - public policy: models of justice, allocation of resources, organizational ethics
  - teaching / mentoring: personal boundaries, confidentiality, fairness, honesty
- Different kinds of ethical frameworks
- How current ethical issues arise with new science and technology
- Life-long competency in your clinical area as an ethical requirement
- Code of ethics of your professional association

#### **Skills**

- All health professionals need to understand basic principles of ethical decision-making
- Ethical case analysis and consultation is a specific area – not all will learn this. It involves critical thinking and negotiation, in addition to interpersonal skills
- MCH leaders should know how to get assistance for dealing with complex ethical issues.

## 5. MENTORING (application)

*An MCH leader invests in the next generation of MCH leaders by providing direction, guidance, nurturance and support to impart knowledge, skills, confidence and an abiding commitment to MCH. Mentoring is a process and product of leadership development, and a sign of professional maturity; an MCH leader mentors the next generation and instills in them the obligation to do likewise.*

**Intrinsic capacities** important for this competency include compassion, empathy, emotional maturity, the ability to establish trust and rapport (interpersonal and communication skills), critical thinking (for goal setting and problem solving), honest self-reflection (internal process), a personal code of ethics (ethics) and the ability to maintain appropriate boundaries in professional relationships.

**Attitudes:** Hallmarks of an MCH leader-mentor include a valuing of the role of mentor and of reciprocal relationships, enthusiasm for supporting others' achievements, and respect for others with different interests and priorities. A MCH leader-mentor must have the ability to identify and withhold personal biases in favor of what is best for the mentee, and the maturity and self-confidence to be challenged without taking personal offense.

**Knowledge:** of individual differences in learning styles; awareness of multiple career options and skill sets that can contribute to the MCH mission.

### **Skills:**

- Demonstrates respectful listening and culturally-competent interpersonal skills
- Able to take another's perspective and use it to help them with brainstorming and problem-solving
- Has explicit awareness of self as role model and how to maximize this effect for others' benefits
- Can communicate and maintain personal boundaries (of self and other)
- Helps others define a personal vision or goal and the objectives to achieve the goal
- Encourages others to achieve goals; celebrates small wins
- Conveys concern for another's choices without being judgmental
- Helps others recover from their mistakes
- Helps others reflect on experiences in a way that encourages self-awareness and inspires self-confidence

## 6. CULTURAL COMPETENCY (application)

Definition: In the MCH arena, cultural competency extends beyond ethnic or racial distinctions to include an MCH professional's honoring and respecting differences among individuals, groups and organizations regardless of social or economic class, gender, language, education, intellectual or physical disabilities, or personal belief systems. The MCH leader has knowledge of how these differences influence health behaviors and the provision of health services. Striving to achieve cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment of time.<sup>13</sup>

*A culturally-competent MCH leader is aware of his/her own biases and assumptions about the motivations for individual and organizational behavior. S/he actively seeks to develop his/her own awareness in order to act with reason and open-mindedness in cross-cultural situations, "leaving his/her assumptions at the door." S/he is conscious of the dynamics involved when diverse groups interact and is able to assess the social and cultural issues at stake and integrate this knowledge into his/her actions. S/he recognizes there may not be one 'right way' to solve a problem and thus, is able to tailor health services to meet the needs of the group or family rather than promoting a personal/professional agenda or ideas. In positions of management, s/he integrates cultural competency into MCH organizations or programs, its philosophies, policies, activities, patient-care protocols and health promotion materials. As a mentor, s/he models, advocates for and supports others to develop their own cultural competency.*

**Intrinsic Capacities:** Cultural competency requires open-mindedness and flexibility to think through and select from among multiple solutions or courses of action. The motivation to persist toward a "culturally-competent" solution often reflects intrinsic curiosity. Cultural competency builds on other "core" MCH leadership competencies including communication skills, critical thinking, self-knowledge (internal process) and ethics/professionalism. Trainees come to our programs with some of these qualities and capacities in place; others can be nurtured during the training period.

**Attitudes:** Cultural competency demands humility to accept there are often multiple "right" perspectives and an honest valuing of individual and cultural differences that engenders the trust of individuals and groups. A significant amount of individual motivation and effort are needed to achieve cultural competency. Attitudes associated with culturally competent MCH leaders include honor and respect for others, especially for others with different experiences or opinions; a sense of social justice or fairness; and recognition of the benefits of reciprocity and balance in relationships. Individuals who value cultural competency<sup>14</sup> view it as continuum of values, behaviors, attitudes and practices. They are aware there is always something additional to learn and are motivated to improve their skills in this arena.

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<sup>13</sup> 1994 Amendments to P.L. 103-230, The Developmental Disabilities Assistance and Bill of Rights Act, Administration on Developmental Disabilities, Administration for Children and Families, U.S. DHHS

<sup>14</sup> Cross T, Bazron B, Dennis K & Issacs M (1989). Towards a Culturally Competent System of Care, Volume 1. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center

**Knowledge** about cultural competency within the MCH framework should include familiarity with empirical evidence that links culturally-competent and family-centered health care practices to patients' access to services, participation in prevention programs and compliance with treatment recommendations.

Additionally, training can develop knowledge in the following areas:

- Self-assessment at the individual, professional and organizational levels of cultural competence and the motivation to develop it further
- Models of service delivery and data collection activities that assure maximum participation (or if data collection, maximum "representation") of diverse communities in the design, receipt or delivery of health services or in public health assessment
- Strategies to achieve and maintain a culturally-sensitive and diverse MCH public health and health service delivery systems

**Skills:** A culturally-competent MCH leader has the ability to:

- Engage in cultural self-assessment at the individual and organizational levels
- Adapt delivery of care and resources to assure practices are culturally-competent and family-centered
- Institutionalize cultural competent and family-centered practices in policies and procedures
- Work appropriately in cross-cultural situations<sup>15</sup> and become a catalyst for change to improve individual, program, organizational and systems' cultural competency

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<sup>15</sup> Maternal and Child Health Bureau, Guidance for SPRANS Grant, Health Resources and Services Administration, U.S. Department of Health and Human Services, 1999.

## 7. EVIDENCE BASE AND TRANSLATION OF SCIENCE (application)

*The MCH leader practicing this competency has the ability to find, evaluate, apply and communicate scientific evidence to different audiences. Two different aspects of this competency are emphasized: the finding / evaluation / application of scientific information; and the translation of this science to practice in clinical, administrative, policy and other MCH settings. The former requires an understanding of the scientific method and its limitations; the latter relies on communication, framing and negotiation. Given the rapid increases in scientific information, all MCH leaders must be prepared to evaluate and apply new evidence as it is generated.*

**Intrinsic capacities:** Critical thinking capacities are essential to the understanding, evaluation, analysis and appropriate application of scientific data. Self-reflection is important for honesty in interpretation and review of data. Interpersonal communication skills are critical to translate science to practice. Personality characteristics that may aid the MCH leader practicing this competency include passion, energy, curiosity, creativity and courage (e.g., the courage needed to champion a radical idea!)

**Attitudes:** Important attitudes that are a part of this competency are open-mindedness, a willingness to question and be questioned, a respect for others and a desire listen to them. The MCH leader has a commitment to the MCH mission as his/her underlying motivation, a strong work ethic and commitment to follow-through. In a collaborative environment, the MCH leader must be willing to identify personal biases and inform others about one's own perspectives.

**Knowledge** of the scientific method; ways in which bias enters research; rules of evidence and when it is appropriate to apply them. Difficulties and limitations of applying evidence to the care of individual patients, including socio-cultural factors. Solid background in your own field. Scientific equipoise.

### **Skills:**

Evaluation of science:

- Can find and gather data – knows resources, literature searching
- Evaluates quality of evidence and applies appropriately in context
- Develops scholarly and research projects to address knowledge gaps including quantitative and qualitative methods

Translating to science to policy and practice:

- Demonstrates good listening skills, cultural competency, negotiation skills
- Can critically assess own field and data gaps and implications for MCH populations
- Able to distill and synthesize information for multiple audiences

## 8. NEGOTIATION AND CONFLICT RESOLUTION (application)

*An MCH leader practicing this competency is able to utilize effective negotiation strategies in different contexts to advance MCH goals in clinical, academic, agency/policy or community interactions. S/he approaches the negotiation setting with objectivity, open to new information, but aware of long-term desired outcomes including relationship-building and development of trust. S/he brings the appropriate scientific evidence or other information necessary to support decision-making, while communicating in a manner that expresses concern for others, an interest in their perspectives, and a desire for collaboration and teamwork. S/he recognizes when compromise is appropriate to overcome an impasse, and when persistence toward a different solution is warranted. The MCH leader demonstrates professionalism and personal integrity, a commitment to MCH goals, transparency of vision, and negotiates from this position.*

**Intrinsic capacities** supporting this competency include critical thinking to comprehend, analyze and approach the negotiation setting; internal reflection to understand his/her own position and best interests; communication skills including listening skills to understand others' positions and interests; ethics and professionalism to bring personal integrity and honesty to the negotiation setting. Characteristics that help include patience and calmness, optimism, creativity to seek for mutually satisfactory solutions, passion, flexibility, openness, focus, resilience to learn from mistakes and risk-taking to accomplish change

**Attitudes:** The belief there is more than one way to “win;” that mutually-beneficial solutions are often achievable; that where possible, relationships should be preserved for long-term trust and team-building; that it is important and necessary to learn from mistakes; and that self-awareness is critical to successful negotiation. The MCH leader practicing this competency demonstrates a collaborative, engaged attitude; recognizes the importance of being well-informed; has a “quiet-brain” (i.e., is focused, avoids bias and judgment); has the willingness and courage to set limits where needed; and can tolerate emotional uncertainty when taking risks or setting limits

**Knowledge:** An MCH leader is aware of different styles of conflict management (i.e., avoidance, competing, compromise, accommodation and collaboration), the positive and negative aspects of these, and their appropriateness for different settings. Knowing where others are and their readiness to change (important especially with patients and families seeking to change behaviors, e.g., compliance with treatment plans); factors that may influence their position including cultural orientations.

### **Skills**

- Recognizes own negotiation style
- Recognizes what is appropriate to the setting
- Distances from the immediate emotions of the process in favor of understanding each parties long-term interests (vs. short-term gains)
- Persists through differences to achieve as good an outcome as possible for all parties
- Develops clear goals and a vision and communicates them
- Uses failure as a catalyst for positive change
- Cultivates self-reflection and self-awareness to understand one's own position and interests

## 9. & 10. MANAGEMENT & WORKING WITH ORGANIZATIONS (application)

*An MCH leader practicing this competency provides vision and leadership to any level of organizational authority. S/he brings transparency of purpose and process, and a commitment to using good business practices to further MCH goals and mission. As a manager s/he values and builds on the contributions of others to effect long- term vision and goals. As a manager, an MCH leader uses systems-thinking to plan and budget, negotiate contracts, manage operations and human resources. Finally, s/he realizes the critical importance of aligning the mission and vision of an organization with all strategic planning, processes and outcomes.*

**Intrinsic capacities:** Good communication and inter-personal skills including listening to others; critical thinking skills for decision making; assessment of outcomes; and for realistic and tactical planning, the ability to see the big picture as well as important details; self-reflection and the ability to maintain good boundaries with others. Characteristics that support an MCH leader in the role of a competent manager include honesty, integrity, optimism, persistence, flexibility, openness, self-awareness, resilience, and decisiveness.

**Attitude:** Self-confidence, belief in importance of others and their strengths and ideas; belief in the value of management skills to serve MCH vision and mission; humility and a belief in importance of learning from mistakes and moving forward; belief in the importance of life-long learning (both technical and personal).

**Knowledge:** An effective MCH leader should have at least familiarity with the basic business principles related to marketing, finance and general management (both human resources and change). MCH leaders may need in-depth knowledge in some of these areas depending upon their professional position.

### **Skills:**

- Marketing<sup>16</sup>: understands the customer/consumers of MCH leadership training including students, faculty and staff; potential employers (Title V, other public health agencies, academic institutions, etc.); funding entities (federal agencies, congress, the public); and strategically communicates the value of MCH to these constituencies by framing the product and positioning the institution or program appropriately
- Finance: including budgeting, long term financial planning, ability to understand and interpret financial statements and reports, basic accounting principles
- Managing human resources: understands employee skills needed for tasks to meet long-term goals; matches people's strengths to tasks; uses appropriate employment policies and processes; understands needs for employee development, compensation, advancement and mentoring; delegates appropriately
- Managing change processes: can develop a strategic plan, implement and evaluate it
- Can clearly articulate an approach or vision and maintain transparency of process
- Uses appropriate negotiation and conflict resolution skills
- Develops effective decision-making processes for self and organization

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<sup>16</sup> Defined: The process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods and services to create exchanges that satisfy individual and organizational objectives to serve both buyers and sellers. (American Marketing Association)

- Holds self and others accountable for implementation and follow-up
- Creates a balance between incorporating input of others and fulfilling key long-term goals
- Mentors others, provides feedback sensitively and takes feedback constructively
- Collaborates and build constituencies with key stakeholders inside and outside an organization to effect change.
- Runs and moderates meetings effectively with clear goals related to purpose, process and follow-up

## 11. CONSTITUENCY BUILDING (application)

*An MCH leader practicing this competency is able to create and sustain a coalition of diverse stakeholders with a common vision and purpose that furthers the MCH mission and goals.*

*Constituency building is a critical task of MCH leadership because supporting maternal and child health at the population level requires interdisciplinary, cross-sector collaboration. The MCH constituency-builder moves an agenda forward in conjunction with others, can play the role of leader or participant as needed, and delegates authority to others appropriately.*

*Constituency-building utilizes many core and applied MCH leadership competencies including, for example, communication, critical thinking, ethics and negotiation skills.*

**Intrinsic capacities:** Constituency-building depends on the core competencies of communication; internal reflection; critical thinking and ethics and professionalism. The most effective MCH coalition leaders are in touch with their deepest purposes and internal motivations (self-reflection). Characteristics of personality and temperament that may aid an MCH leader in this task include passion, persistence, self-motivation, optimism, flexibility, creativity, charisma, humility and patience.

**Attitudes:** The successful MCH coalition-builder values the input of others for attaining shared goals; s/he is willing to take input and utilize it. When possible s/he values outcomes that can serve more of the stakeholders, although obtaining those outcomes may be more energy-consuming and time-consuming. S/he accepts that the coalition-builder may make mistakes (e.g., s/he may leave out important stakeholders) and is willing to apologize for mistakes. S/he is willing to ask for help when needed.

**Knowledge:** A solid understanding of the evidence base in the particular area provides the scientific rationale for change and also contributes to the credibility of the leader. S/he is knowledgeable about the context and frame of the different stakeholders

### **Skills:**

- Translates the MCH mission and vision for different audiences, appreciates different points of view (strategic communication; cultural competency)
- Uses effective management strategies for sustaining an effort (strategic planning, evaluation, delegating /sharing responsibility)
- Can apply negotiation and conflict resolution strategies with stakeholders when appropriate
- Demonstrates patience with the extended timeline often required to move collaborative agendas forward
- Continually assesses the environment for pitfalls and opportunities that will affect the constituency's goals
- Able to keep moving an agenda forward, keeping the long-term goals in mind, while adjusting to new input and making mid-course corrections as needed

## 12. POLICY AND ADVOCACY (application)

A policy is a decision that affects a large number of people; it can be implemented in many settings - academic, clinical, organizational or governmental.

*An MCH leader practicing in the policy arena advances the best achievable policy from among alternatives, recognizing both the pressing MCH population needs and the practical constraints and compromises that policy development entails. Policy development and enactment is a complex task that depends on other competencies, including constituency building. All MCH leaders should have some knowledge of what is involved in public policy development and how public policies impact MCH populations. Regardless of the context or focus of his or her work, an MCH leader is always an advocate for improving the health and well-being of children and families.*

**Intrinsic capacities:** Policy development and enactment require the core competencies of communication, critical thinking, self-reflection and ethics/professionalism, which have intrinsic aspects to them. Personality characteristics which can assist the MCH leader in the policy arena include patience, persistence, courage and optimism. Leaders with charisma who project their passion for MCH may be especially successful in some advocacy settings.

**Attitudes:** An MCH leader believes in the policy process to advance the health of MCH populations, respects diverse opinions, is willing to accept appropriate compromises to move MCH goals forward and is non judgmental

**Knowledge:** S/he has scientific evidence and clinical expertise in the domain which a particular policy addresses; is cognizant of the social, cultural and political contexts that dictate policy and advocacy activities; understands and applies principles of policy analysis

### **Skills:**

- Engages in policy analysis - the systematic process of choosing the best policy among alternatives by applying appropriate evaluative criteria
- Understands values underlying policy choices
- Understands and uses data, levels of evidence, and other evaluative criteria (e.g., fairness) in decision making
- Advocates a point of view; can communicate an agenda to different audiences, including media; knows how to separate scientific evidence from emotion and how to use both
- Understands the potential impact of policies on culturally diverse populations
- Applies negotiation and conflict resolution skills as appropriate to achieve optimal outcomes
- Uses effective management skills to plan, implement and evaluate policy efforts
- Builds constituencies necessary to enact changes in MCH policy



**MCH Working Conference:**  
**The Future of Maternal & Child Health Leadership Training**

**April 19-20, 2004**  
**University Tower Hotel, Seattle, Washington**

**CONFERENCE AGENDA**

**DAY ONE: Monday, April 19, 2004**

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|----------------|---|
| 7:00 - 8:00 am | Registration and Continental Breakfast  |
| 8:00 - 8:15 am | Welcome and Opening Remarks <ul style="list-style-type: none"><li>• <b>M. Ann Drum, DDS, MPH</b>, Director, Division of Research, Training and Education, Maternal and Child Health Bureau</li><li>• <b>Laura Kavanagh, MPP</b>, Training Branch Chief, MCH Training Program, Maternal and Child Health Bureau</li><li>• <b>Martha Somerman, DDS, PhD</b>, Dean, School of Dentistry, University of Washington (UW)</li></ul> Setting the Stage <ul style="list-style-type: none"><li>• <b>Wendy E. Mouradian, MD, MS</b>, Conference Co-Chair and Associate Director, MCH Center for Leadership Education in Pediatric Dentistry, UW</li></ul> |
| 8:15 – 8:30 am | Looking Back: Summary of 1987 and 1988 MCH Leadership Workshops <ul style="list-style-type: none"><li>• <b>Colleen Huebner, PhD, MPH</b>, Conference Co-Chair and Director, Maternal and Child Public Health Leadership Training Program, School of Public Health and Community Medicine, UW 1987, 1988 Conference members</li><li>• <b>Bruce Shapiro, MD</b>, Johns Hopkins University</li><li>• <b>Rose Ann Parrish, MSN</b>, University of Cincinnati</li><li>• <b>Mary Richardson, MHA, PhD</b>, UW</li></ul>   |
| 8:30 – 9:15 am | Looking Forward: Leadership in the Public Good Keynote Speaker <ul style="list-style-type: none"><li>• <b>Dominick DePaola, DDS, PhD</b>, President and CEO, The Forsyth Institute, and Principal, The Santa Fe Group</li></ul>   |
| 9:15 - 9:30 am | Break   |

9:30 – 11:15 am	<p>Defining Leadership for the Future: Concepts and Definitions of Leadership in Different Professional Settings</p> <p>Facilitators:</p> <ul style="list-style-type: none"><li>• <b>Wendy Mouradian, MD, MS</b></li><li>• <b>Greg Redding, MD</b>, Professor of Pediatrics and Director, Leadership Education in Pediatric Pulmonary, UW</li></ul> <p>Panel:</p> <ul style="list-style-type: none"><li>• <b>Bruder Stapleton, MD</b>, Chair, Department of Pediatrics, University of Washington – <i>representing education</i></li><li>• <b>Joel Berg, DDS, MS</b>, Chair, Department of Pediatric Dentistry, University of Washington, former Vice President for Scientific Affairs, Philips Oral Health Care – <i>representing business</i></li><li>• <b>Tracy E. Garland</b>, President and CEO, Washington Dental Service Foundation – <i>representing foundations</i></li><li>• <b>Maxine Hayes, MD, MPH</b>, State Health Officer of Washington, Community and Family Health – <i>representing government</i></li></ul>
11:15 – 11:30 am	<p>Framing the Charge for Workgroups: Discussion of 12 competencies and training experiences</p>
11:30 – 11:45 am	<p>Break</p>
11:45 – 2:00 pm	<p>Lunch and Twelve Breakout Workgroups for Domains, Competencies and Skills (sessions described below)</p>
2:00 - 2:15 pm	<p>Break – return to large group meeting room (Ballroom)</p>
2:15 - 3:15 pm	<p>Reports from Workgroups (5 minutes each)</p> <p>Facilitators:</p> <ul style="list-style-type: none"><li>• <b>Jeff McLaughlin, MD</b>, Professor of Pediatrics and Director, LEND, UW</li><li>• <b>Wendy Mouradian, MD, MS</b></li></ul>
3:15 - 4:45 pm	<p>Survey of Current Leadership Practices: Findings from the 2003 Progress Reports and Selected Best Practices</p> <ul style="list-style-type: none"><li>• <b>M. Ann Drum, DDS, MPH</b>, Director, Division of Research, Training and Education, Maternal and Child Health Bureau</li><li>• <b>Laura Kavanagh, MPP</b>, Training Branch Chief, MCH Training Program, Maternal and Child Health Bureau</li><li>• <b>Virginia Reed, PhD, MSN</b>, Research Associate Professor, Dartmouth Medical School</li><li>• <b>Angela Rosenberg, PT, DPH</b>, Center for Development and Learning, University of North Carolina at Chapel Hill</li></ul>
5:00 pm	<p>Conference Day Ends</p>
6:30 - 7:00 pm	<p>No-Host Bar and Networking</p>

- 7:00 - 8:30 pm                      Dinner and Invited Speaker  
Ethics, Public Health and Leadership
- **David Nash, DMD, MS, EdD**, Professor of Pediatric Dentistry and Bioethics, University of Kentucky Medical Center

**DAY TWO Tuesday, April 20, 2004**

- 7:00 - 7:45 am                      Continental Breakfast at Hotel
- 7:45 - 8:00 am                      Overview and Charge for the Day
- **Wendy Mouradian, MD, MS**
- 8:00 – 9:00 am                      Measurement Frameworks  
Facilitator:
- **Colleen Huebner, PhD, MPH**  
Speaker:
  - **Judy Morton, PhD**, Vice President, Quality Integration and Improvement, Swedish Hospital, Seattle, and Baldrige Examiner  
Discussants:
  - **Joel Berg, DDS, MS**
  - **Virginia Reed, PhD, MSN**, Research Associate Professor, Dartmouth Medical School
  - **Greg Redding, MD**, Professor of Pediatrics and Director, Leadership Education in Pediatric Pulmonary, UW
- 9:00 - 9:15 am                      Charge to Workgroups: What does the MCH leader look like practicing the specific competency? How do we measure outcomes of leadership training?
- 9:15 – 9:30 am                      Break
- 9:30 – 10:30 am                      Twelve Workgroups: Discussion of measurement and evaluation (Registrants will receive specific instructions related to session discussion format before the conference.)
- 10:30 – 11:30 am                      Workgroup Report and Wrap Up
- **Jeff McLaughlin, MD** and **Wendy Mouradian, MD, MS**
- 11:30 am                              Conference Ends – *Check out and pick up box lunch*
- 12:00 – 12:30 pm                      Break
- 12:30 - 3:00 pm                      Optional Post-Conference Workgroup in Ballroom:  
Summary of recommendations

**Breakout Sessions Work Groups**

<b>Working with Others</b>	<b>Working with Facts, Policies, and Organizations</b>	<b>Working within Oneself</b>
<p><b>#1 Leading Others: The Role of Communication – Regents Room</b> Facilitators: Emans, Huebner</p>	<p><b>#6 Translating Science and Evidence to Practice – Chancellor Room</b> Facilitators: McLaughlin, Blasco</p>	<p><b>#10 Internal Process of Becoming a Leader – Chancellor Room</b> Facilitators: Kieckhefer, Rosenberg</p>
<p><b>#2 Building Constituencies – College Room</b> Facilitators: Mouradian, DePaola</p>	<p><b>#7 Policy and Advocacy Skills – Presidents Room</b> Facilitators: Margolis, Shapiro</p>	<p><b>#11 Critical Thinking and Problem-Solving - Ballroom</b> Facilitators: Redding, Rounds</p>
<p><b>#3 Cultural Competency – College Room</b> Facilitators: Chavez, Stuart</p>	<p><b>#8 Management Skills – Regents Room</b> Facilitators: Berg, Okada</p>	<p><b>#12 Ethics and Moral Commitment and Professionalism – Board Room</b> Facilitators: Nash, Robins</p>
<p><b>#4 Negotiation/Conflict Resolution – Presidents Room</b> Facilitators: Leggott, Slayton</p>	<p><b>#9 Working with Organizations as Systems - Ballroom</b> (Combined with group #8)</p>	
<p><b>#5 Mentoring and modeling for trainees and faculty - Ballroom</b> Facilitators: Iwaishi, Rees</p>		

## PLENARY SESSION SUMMARIES

### DAY 1: Monday, April 19, 2004

#### Conference Opening Welcomes and Introduction

- **M. Ann Drum, DDS, MPH**, Director, Division of Research, Training & Education, Maternal and Child Health Bureau, Health Resources and Services Administration, USDHHS
- **Martha Somerman, DDS, PhD**, Dean, School of Dentistry, UW

#### Setting the Stage

- **Wendy Mouradian, MD, MS**, Conference Co-Chair and Associate Director, MCH Center for Leadership Education in Pediatric Dentistry, UW

Dr. Mouradian discussed leadership in the MCH context as a moral mandate. MCH professionals share this calling to leadership because of profound health disparities in MCH populations, the investment of public funds in training and the trust placed in them by the public, the special knowledge and expertise of MCH professionals, the vulnerability of MCH populations and the overall importance of MCH populations for the future of society.

#### Looking back: 1987 - 1988 Maternal and Child Health Leadership Conference

- **Colleen Huebner, PhD, MPH**, Conference Co-chair, and Director, Maternal & Child Public Health Leadership Training Program, School of Public Health & Community Medicine, UW

1987, 1988 Conference Members:

- **Bruce Shapiro MD**, Johns Hopkins University
- **Rose Ann Parrish, MSN**, University of Cincinnati
- **Mary Richardson MHA, PhD**, UW

The first working conference on MCH leadership was convened with faculty from LEND programs. The idea of MCH leadership was really an emergent one; and no one was quite sure how to define it, how to measure it and how to document that it was being done. It was agreed that “you recognized it when you saw it,” but participants wondered if leaders were born or made; did the leadership training make any difference? Selection criteria for trainees were identified: (1) Good communication /interpersonal skills; (2) Career goals that are compatible with the content of the program; (3) Trainees who are beyond the entry level; (3) Previous evidence of leadership; and (4) Self-motivation.

The numerous variables that interact with someone’s leadership trajectory make it difficult to demonstrate the impact of training. Leadership criteria could be articulated, but training to them did not necessarily ensure that leadership would emerge. The environment can encourage or hinder leadership development. Participants recognized that leadership was a process, and that it could emerge at many levels of an organization. They recognized both the dynamic and developmental nature of leadership that evolved over time, and the highly personal nature of that

trajectory. Who you are as a person is who you will be as a leader. The key question remains of how to train people to address problems and challenges that we cannot yet envision. For that reason, rigid prescriptions for MCH training will not suffice.

### **Keynote Address - Looking Forward: Leadership in the Public Good**

- **Dominick DePaola, DDS, PhD:** President and CEO, The Forsyth Institute, and Principal, The Santa Fe Group

Using examples from the airlines industry and Disney Institute, Dr. DePaola stressed that leadership is about exceeding expectations. Leadership is a process, not a product, and it can emerge from many levels. The people who work for you must come first, because if they are not happy, the customer will not get good service. Leadership is about influencing change, taking risks, and helping people recover from mistakes. No one has all the leadership “competencies” typically described, but *someone* on your team better have these qualities. Dr. DePaola used the term “change ninja” to designate individuals on your team, and beyond, who can take the message and help bring about change in your organization or in a system.

Dr. DePaola provided a number of definitions of leadership: “Leadership is a dynamic relationship based on mutual influence and common purpose between leaders and collaborators in which both are moved to higher levels of motivation and moral development as they effect real, intended change.”<sup>17</sup>

And from Freiberg et al., “Leadership is the practice of helping people envision and then participate in creating a better world. Leadership raises individuals, organizations, and communities to higher levels of moral development – that is, the obligations and responsibilities associated with bettering the human condition.” Leaders are servants by nature. Leadership inspires motivation, enriches the human condition, raises people to higher levels of moral development, teaches and invests in the next generation, influences change, achieves purposes that reflect the common good!<sup>18</sup> This type of leadership is often described as “transformational leadership.”<sup>19</sup>

Dr. DePaola reviewed various leadership styles: arrogant, confrontational, plodding, regressive, status quo and visionary. Effective leaders have the ability to move multiple constituencies; a willingness to take risks and push the envelope; challenge traditional values and the status quo; be flexible and tolerant of multiple positions; exhibit sustained resolve; be “savvy” about the political and social landscape; create coalitions, partnerships and collaborations; and nurture interdisciplinary and cross-cultural approaches. Moreover, a leader needs compassion and caring, legitimacy, public trust, expertise, persuasion, a 360-degree view, communication and engagement skills, ability (flexibility) to reconcile the public paradox and courage.

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<sup>17</sup> Roast, J, Leadership for the 21st Century, New York, Praeger, 1991

<sup>18</sup> Freiberg, K, Freiberg, J, Nuts, New York, Broadway Books, 1996

<sup>19</sup> For detailed discussion of transformational leadership see The Kellogg Leadership Studies Project: Transformational Leadership. [http://www.academy.umd.edu/publications/klspdocs/transformational\\_index.htm](http://www.academy.umd.edu/publications/klspdocs/transformational_index.htm) Accessed September 2, 2004.

In the context of working with communities, leaders (i.e., academic, research or public health leaders) must understand community needs and capacities, be willing to engage societal issues consonant with their academic or public health mission, establish shared goals and implementation strategies, understand community expectations, measure outcomes and be persistent!

Dr. DePaola discussed spheres of influence of health care providers and of academic institutions, and the way each could interact with issues beyond their immediate patient or environment to help move forward the public good. In the case of the academic institution, this perspective includes a vision of education, research and service combined with community outreach, community empowerment and partnership. In the case of providers of individual health care, access and immediate socioeconomic factors are seen as domains of professional obligation; while broad socioeconomic and global health factors are seen as domains of professional aspiration.<sup>20</sup>

## Morning Panel

### Defining Leadership for the Future: Concepts and Definitions of Leadership in Different Professional Settings

Facilitators:

- **Greg Redding, MD**, Professor of Pediatrics and Director, Pediatric Pulmonary Leadership Training Center, Children's Hospital and Regional Medical Center, UW
- **Wendy Mouradian, MD, MS**, Conference Co-Chair

Panelists:

- **Bruder Stapleton, MD**, Chair, Department of Pediatrics, UW School of Medicine – *representing the educational / academic perspective*
- **Joel Berg, DDS, MS**, Chair, Department of Pediatric Dentistry, UW School of Dentistry, former VP for Scientific Affairs, Philips Oral Health Care - *representing the business and academic perspectives*
- **Tracy E. Garland**, President & CEO, Washington Dental Service Foundation - *representing the philanthropic perspective*
- **Maxine Hayes, MD, MPH**, State Health Officer of Washington, Community and Family Health - *representing government and the public health perspective*

**Bruder Stapleton.** Drawing on his personal experiences and professional development, Dr. Stapleton emphasized that leaders are coaches, that they bring others together toward a common goal, and are responsible for the success of the group as well. He cited the example of the legendary football coach Bear Bryant, who remained a successful leader across 4 decades of

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<sup>20</sup> Gruen, RL, Pearson SD, Brennan TA. Physician-citizens—Public roles and professional obligations JAMA, January 7, 2004; 292 (1): 94-98

different generations of people with different values. The challenge of inter-generational values is among the most difficult leaders face today.

Leadership is more than management, and it is more than personal scholarship. It involves leaving an area in which you have been an expert, to enter one in which you are not. You give up part of your identity -- who you were before taking on the leadership role (in Dr Stapleton's case, a nephrologist).

Dr. Stapleton stressed that leaders are VIPs: they have vision, integrity and passion. He cited his own mission to improve the health of children. At the same time, leaders must act with humor and kindness, and think strategically. Leadership requires study, thought, commitment and self-examination. Leaders must act in teams: today's faculty expect and want involvement. Don't make important decisions alone: surround yourself with the right people. The most important task of a leader in education is the recruitment of good, motivated, intelligent faculty: the success of the organization depends on others. Next is lining up the talent of the faculty with the jobs to be done. As you develop leadership among the faculty, remember that great clinicians may not always be great leaders. But only by developing leadership beyond yourself can the vision be sustained.

**Joel Berg.** Dr. Berg compared leadership in academic and business settings, and noted the similarities and differences. Both want a return on investment, but the products are different. The role of leadership may be similar, but desired outcomes are different. Academic outcomes are more varied and more difficult to measure and value. With industry, it is the products or services, and the bottom line is easier to measure.

In both cases, there is the importance of setting a vision and sticking to it, developing transparency of all processes, and measuring outcomes. In business, there is emphasis upon "leadership training;" in academics, it is seen as "faculty development." Most people are conflict-averse, and they can avoid much conflict by practicing transparency in all processes. No matter what the setting, leaders should always be prepared to revisit their vision and re-engineer it if they are off-course. There is a difference between strategic planning (based on the vision) versus operational planning (reflecting processes to achieve the vision). And in both academics and business, prioritization, focus, and resource management are important. In general, managers (as opposed to leaders) execute the vision.

In the current context our question would be: What is the core competence (product) of MCH leadership training? What is the unit of measurement for this?

**Tracy Garland.** Ms. Garland discussed leadership from the perspectives of philanthropy and business. In the setting of philanthropy, the challenge is how to lead when the determining factor is not the public ballot or the bottom line. In philanthropy, one is always looking for opportunities to magnify impact of resources. There is the need to match vision with commitment and thinking with action, to turn science into practice, and to be bold but realistic ("practical visionaries") to see what is possible now. Finally, it is important to learn the lesson of letting go, not being possessive about the good one is creating. There is always the difficulty of recovering with grace when you face a dead end (which she referred to as a "pirouette in the

alley”). Leaders may also face the difficulty of transitioning from one sector to another (e.g., from business from philanthropy).

**Maxine Hayes.** Dr. Hayes described her personal experiences in a strongly motivated family in rural Mississippi. After a career in medicine and then switching to public health, Dr Hayes realized that physicians are trained to be solo practitioners, and one has to move beyond the solo act to be a public health leader and move to a team mind-set. Dr Hayes reviewed different models of leadership including hierarchical and servant leadership models. Leadership today, especially in public health or in government, cannot be about “me” but must be about others; it must be collaborative. Leaders need good skills in communication, listening, negotiation and persuasion.

Dr. Hayes also referred to the IOM Report on the Future of Public Health in the 21<sup>st</sup> Century, which emphasizes the importance of communication including strategic communication, knowledge transfer and use of the media and technology. Paraphrasing the remarks of William Foege, MD, MPH (former Director of the Centers for Disease Control and Prevention), Dr. Hayes closed by saying that the future of public health belongs to those who can collaborate.

**Additional points from Q&A session:**

- Regarding data: Data are important, facts are a tool to provide you with power, but frame always trumps facts! Thus there is a need for strategic communication, understanding how people see an issue. A leader must always be able to translate issues in which they are not necessarily an expert.
- Key leadership pitfalls: One risk to effective leadership is not dealing with ineffective employees. Again, transparency of the vision becomes a particularly important tool for dealing with those who are not “on board” with the mission and vision.
- How do you include a servant-leadership focus: It is often hard to teach to the underlying dimensions of compassion and spirituality on which much of leadership may be based – some generations are harder to reach than others. You can address it, perhaps, through stressing importance of personal renewal, which may include a spiritual component.
- Empowering patients and parents: How do we inculcate leadership in the consumer? How do we put them in the position to be change agents? How do we help give legitimacy to and empower them as a group (as opposed to just the individual)?

**Workgroups’ Reports on the 12 Competencies and Skills of Leadership** (summaries in body of the report)

**Afternoon Panel**

**Survey of Current Leadership Practices: Findings from the 2003 Progress Reports and Selected Best Practices**

- **Laura Kavanagh, MPP**, Training Branch Chief, MCH Training Program  
Maternal & Child Health Bureau
- **Virginia Reed, PhD, MSN**, Research Associate Professor, Center for Educational Outcomes, Dartmouth Medical School

- **Angela Rosenberg, PT, DrPH**, Assistant Professor, and Training Director LEND-UCEDD University of North Carolina

**Laura Kavanagh.** Ms. Kavanagh articulated the MCHB training vision which focuses on leadership, and is distinguished from the larger workforce development programs located within the Bureau of Health Professions. MCHB has chosen a leadership training focus to magnify the impact of relatively few dollars. MCH leadership training programs are focused on outcomes other than clinical excellence in a particular discipline. Outcome measures include, among others, policy /advocacy, academic, clinical and other leadership activities. There are now 10 categories of long-term leadership training programs as well as the training category Graduate Medical Education and Summer Mentor Program (formerly Historically Black Colleges and Universities), for 11 in all.

The 2003 progress reports asked grantees to report on leadership activities. A number of different approaches and innovations were identified.

Approaches to encourage individual growth included:

- Curriculum development
- Presentation of research findings
- Trainee-initiated projects
- Field experiences with youth-serving agencies
- Presenting testimony
- Leadership journals

Group leadership exercises included:

- Team-building exercises
- Leadership seminar series

Other innovations included:

- Long-term trainees mentoring others
- Public policy Institutes (NM, NH)
- An alumni leadership award (OR)
- Trainee research day (WA)
- Foundations of MCH leadership (MN)
- Leadership trainees/leadership track (MA)
- Policy concentration
- Research to practice literature reviews (AR)
- Leadership development series (IL)
- From idea-to-grant proposal

**Virginia Reed.** Dr. Reed described an approach to assessment of MCH training programs intended to develop data-driven standards of excellence in leadership education. Key questions included: 1) What contributes to leadership? 2) How does it develop? 3) How can leadership and its development be measured? 4) What are the best ways to provide effective, evaluative feedback that tracks the development of leadership?

Dr Reed's qualitative research began by analyzing leadership narratives included in the 2003 progress reports to understand how program directors describe their program's leadership activities and exemplary graduates and faculty. Dr. Reed related these descriptors to MCH Leadership Training Performance Measure # 8. Many descriptors matched the MCHB categories, although public health/policy and advocacy examples were provided less frequently than academic and clinical measures. This may be related to the fact that these outcomes are less aligned to academic incentives; also, they tend to be accomplished later in one's career trajectory. Additionally, collaboration was mentioned frequently by program directors as a leadership activity.

Second, focus groups were carried out at national MCH meetings to further explore concepts of leadership and how it develops. Five focus groups were held at 3 meetings, with a total of 61 participants including program directors, faculty and trainees.

An underlying assumption of the focus group research was that developing leadership can be identified by a "trace" that does not as yet rise to the level of leadership in action but may suggest future leadership potential. Early competence may be a marker for leadership, and suggests a set of skills and motivations that allow a trainee to do "more than is expected sooner than is expected" (as coined in the 1987-1988 MCH Leadership Conference Report).

Conceptual clusters suggested by analyses of the focus group discussions included:

- 1) Who trainees are (past accomplishments and personal characteristics)
- 2) Knowledge (active participation in learning and demonstrated applications of learning and problem solving)
- 3) Interpersonal skills (interaction / communication and collaboration)
- 4) Workplace skills (organization and initiative)
- 5) Family-centered care

Third, Dr. Reed carried out a review of the literature for additional insights. The leadership literature reveals that ideas of leadership evolve and change over time. There has been a dramatic increase in interest in and citations across the past two decades. Leadership is felt to consist of an interaction of traits and behaviors; leadership is developmental in nature. It can be assigned or can emerge spontaneously. Leadership and management are not the same. There are also inherently ethical aspects to the notion of leadership.

Finally, there are cultural dimensions to the notion of leadership, including gender-specific issues. Some studies have addressed the latter but few consider the broader implications of leadership in an increasingly diverse culture. For example, the notion of leaders and followers may be culturally determined.

**Angela Rosenberg.** Dr. Rosenberg presented an innovative approach to collaboration across the 5 MCH leadership programs at the University of North Carolina, Chapel Hill in Public Health, Nutrition, Pediatric Dentistry, Social Work and Leadership Education in Neurodevelopmental Disabilities (LEND). Collaborations include formation of a training programs collaboration with shared philosophy, curriculum, a training agenda and a vision for combined interdisciplinary training. New initiatives include a leadership intensive workshop and a Ropes course (3 days); a joint conflict resolution workshop; and leadership reflection activities. For the future, the plan is to develop a core-course training agenda including a formal interdisciplinary cultural

competence curriculum, and a vision for seamless interdisciplinary MCHB training across the campus.

## DAY 2: Tuesday, April 20, 2004

### Measurement Frameworks

#### Invited Speaker

- **Judy Morton, PhD**, Vice President, Quality Integration and Improvement, Swedish Hospital Seattle, and Baldrige Examiner

#### Facilitator

- **Colleen Huebner, PhD MPH**, Conference Co-Chair

#### Discussants

- **Joel Berg, DDS, MS**, Chair, Department of Pediatric Dentistry, School of Dentistry, UW
- **Virginia Reed PhD, MSN**, Research Associate Professor, Dartmouth Medical School
- **Greg Redding, MD**, Professor of Pediatrics and Director, Leadership Education in Pediatric Pulmonary, UW

Dr. Morton provided an overview of the history and current status of the Baldrige National Quality Program's Criteria for Performance Excellence.<sup>21</sup> The Malcolm Baldrige National Quality Award exists to recognize U.S. organizations for performance excellence in business, education and health care. The criteria provide a framework for assessing and measuring performance on a number of key indicators with the goal of delivering high-quality products to consumers and improving organizational effectiveness. Organizations can go through the Baldrige process with the goal of applying for the Baldrige award, or solely for self-assessment and quality improvement.

The Baldrige Performance Excellence Model includes a core set of values and 7 key inter-related elements to optimize organizational performance including:

1. An organizational profile
2. Leadership
3. Strategic planning
4. A "customer" (patients, students, market) focus
5. Faculty and staff focus
6. Process management
7. Measurement, analysis and knowledge management

The model applies to various sectors and organizations and is not prescriptive. Among its core values are: visionary leadership, organizational and personal learning, management by fact, a focus on results and creating value, a systems perspective, agility, focus on the future and managing for innovation.

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<sup>21</sup> Baldrige National Quality Program Criteria for Performance Excellence, [www.quality.nist.gov](http://www.quality.nist.gov)

Dr. Morton described how the Baldrige framework could be applied to MCH leadership training. It would emphasize: 1) the alignment of vision, mission, process and outcomes; and 2) performance measurement based on reliable and valid measures that are sensitive to change in performance over time and to differences in performance compared to other groups. A Baldrige approach to MCH leadership training program outcomes would specify, for example, measures of:

- student learning (e.g., percent of graduates serving targeted populations)
- student or patient results (e.g., satisfaction)
- faculty and staff results (e.g., faculty publications, professional development expenditures, percent of minority faculty / staff / students compared to the community to be served)
- organizational effectiveness (e.g., employer ratings of graduates, percent of graduates in leadership positions within 5 or 10 years of graduation)
- governance and social responsibility (e.g., hours per person in community outreach)

To develop indicators of “performance excellence” for the MCH leadership training program, Dr. Morton reminded us of the need to:

- link outcomes to the mission and goals of the national training plan
- balance outcome measures with process measures
- include key stakeholders in the process of identifying measures
- recognize that training program categories might have both common and unique measures
- consider measures that monitor internal growth over time as well as performance of the program (or trainees) compared to other programs

Dr. Morton also recognized that the context of the training programs, within academic settings, could create competing systems and competing goals.

### **Discussants’ Responses, and Audience’s Question and Answer Period with Discussants (paraphrased)**

**Joel Berg.** An advantage of the Baldrige method is its emphasis on segmenting the process into individual components (e.g., of training or production), so that when things start to not go right, you can take corrective action with precision. The Malcolm Baldrige approach is nothing more than identifying a set of processes that lead to a result in order to determine which points in the process you can tweak to make performance even better. Baldrige values process as much, or more than, than results. In the scoring for the award, more points are allocated for process than results. If the processes are working correctly, they achieve your results.

Another point about Baldrige is that the self-assessment becomes engrained in the organization, not external to it. The objects of the assessment are the actual elements of how you run the organization.

A third point, true in business, in healthcare and in education, is that Baldrige Award winners are excellent because of the people involved. A big part of the self-assessment and improvement is satisfaction of the people involved – the employees, service providers and faculty, as well as the consumer (e.g., trainees or patients). This returns us to a point made yesterday about the

importance of transparency to effective management. With Baldrige winners, you see this transparency at all levels – you can walk down the hall, stop someone and ask “What’s the mission of the organization? What are we here for?” and they know, they all know.

**Question:** Does this type of excellence depend on strong leadership?

**Judy Morton.** The commitment and level of alignment of every person’s contribution to the mission is felt across the organization, but it does require major senior leadership commitment, support, and the daily living of it, as Joel Berg mentioned.

**Question:** Doesn’t this take years?

**Judy Morton.** It is not a quick fix. Many organizations that have won a Baldrige award have used the criteria as a way of improving their organization for several years before winning.

**Question:** Can a component of an organization apply or must the whole agency apply?

**Judy Morton.** The criteria can apply to any size of group.

**Question:** How do the Baldrige criteria mesh with other accrediting activities?

**Judy Morton.** You need to go through accreditation clearly; Baldrige can be very supportive because it contributes to further excellence.

**Question:** How can we get people to accept self-assessment?

**Joel Berg.** If self-assessment is not integral to the way you do business, it is natural to be averse. Why do the extra work of assessment for no reason? When it’s perceived as a system that allows us to identify processes that can be improved to make results better, then people will buy in to it.

**Virginia Reed.** Instead of thinking about assessment as a focus on what we aren’t doing (that we should do), we can use assessment to identify what we are doing well (that we should do more of). This is one way to change the environment in which we give feedback, to make giving and receiving feedback and learning pleasurable, and something in which people want to be involved.

**Question:** How can the Malcolm Baldrige analysis be carried out in resource-constrained organizations such as state-funded agencies?

**Judy Morton.** In resource-constrained organizations, getting clear about key measures of success is especially important.

**Colleen Huebner.** One gem I learned from the Baldrige approach is alignment. If you can get clear on the processes that carry you from vision to the outcome, you’ve got a framework for prioritizing and decision-making, and sometimes that means you’ll have to say – we really can’t do that right now. With limited resources, you might need to put some things on hold to stay focused on vision and strong alignment. Baldrige helps you prioritize.

**Greg Redding.** The Baldrige approach brings up a lot of important questions about who we are – how aligned are we as categories? How aligned are we as programs? And frankly, what is the product? I’m not so sure we’re training to the same product among our different categories and I’m not sure we should be. The discussion of the Baldrige approach raises questions about what the “organization” level is – do we see ourselves collectively or individually as we carry out our training mission?

**Question:** Is there a way for leadership training programs interested in learning more about the Baldrige approach to talk with each other?

**Colleen Huebner.** To my knowledge our conversation today is the first. One outcome of this meeting will be to recommend follow-up activities – a forum for discussion, as you’ve suggested, could be one of those recommendations.

**Wendy Mouradian.** One of the things I’ve picked up in conversations at the conference is an anxiety about how our own discussion of assessment and outcome might be used to constrain us in the future. Laura (Kavanagh), could you respond to that?

**Laura Kavanagh** You have to look at it at multiple levels. Programs are already working at the level of self-assessment for quality improvement. There’s been some innovation in looking at graduates of an entire category; PPC has done that. At the national level, to defend these programs to congress requires outcome data, and not just quantitative data; qualitative data too, especially the experiences of the trainees. We have to struggle with this issue (of assessment). “I want you to view this as a partnership for us to come up with outcomes (that) make sense to both of us.”

## **PARTICIPANTS' EVALUATION OF THE TWO-DAY CONFERENCE**

### **ABSTRACT**

An evaluation survey (see appendix) was completed by nearly two-thirds (63%) of MCHB training program faculty who attended the conference. Respondents were from 10 of 11 MCHB Long Term Training Program categories. Respondents rated the conference very high for advancing understanding of both faculty and trainee leadership, and for providing opportunities to collaborate within and across institutions. A high value was placed on working with individuals from other MCH leadership training programs; the majority of participants identified discussions, bringing people together and or small workgroups as the single most important aspects of the conference. Participants recognized the importance of ongoing evaluation of the process and products of the leadership training programs; however, there was no consensus on how this should be done. A sample conceptual framework, the Baldrige approach to performance evaluation, received a generally positive response. Some respondents who expressed misgivings about its applicability to MCHB leadership training were concerned about the intense commitment of time and resources necessary to fully implement the Baldrige approach.

Survey respondents recommended continued opportunities to work further on leadership criteria, training curriculum and outcome evaluation. The need for faculty development in order to maximize the benefit of the training experience for trainees and encourage their long-term commitment to MCH was identified.

Although there was no formal presentation about teaching MCH oral health within the leadership curricula, oral health examples provided by the keynote speakers motivated participants to consider strengthening the oral health component of their own training programs. Furthermore, this conference stimulated dental professionals to include other MCH competencies into their training programs.

The majority of participants indicated the need for a written report summarizing the progress made at this conference. Many recommended a follow-up meeting and expressed a desire to continue work toward developing leadership competencies across categories. These suggestions are reflected in the recommendations set forth in the Executive Summary and Commentary, "Recommendations," section of this report (page 18).

## Overview of Conference Goals and Processes to Achieve Goals

The two-day conference was designed as a working meeting to create a conceptual framework for MCH leadership and leadership training. Four questions posed by MCHB added specificity to this goal:

- What is the definition of leadership in the MCH context?
- What are the key leadership domains, competencies and skills for trainees and for faculty?
- What tools, curricula and experiences are needed to develop leadership in training programs?
- What are the methods to measure process and outcomes of MCH leadership training?

Embedded in these questions is the challenge to consider MCH leadership in its most “pure” sense – that is, to identify qualities of MCH leadership and of training experiences that transcend differences in clinical disciplines or program types. To begin this task, the conference drew together faculty representatives from the MCHB-supported long-term training programs. Faculty from all MCHB-supported long-term programs were invited to attend. Plenary sessions and expert panels were scheduled each day to stimulate discussion and maintain progress toward the conference goals. When their schedules allowed, the invited speakers were encouraged to stay on and join in the small workgroup sessions. In addition to the featured speakers, conference participants included several national MCHB leaders, representatives of national centers for education research and independent consultants. The total number of participants was limited to a maximum of 125 to allow for manageable work group size and discussion.

## **PURPOSE AND METHOD OF THE EVALUATION**

Participants were asked to complete a brief opinion survey at the close of the conference. The 22-item survey asked for feedback about four aspects of the conference: 1) whether the conference helped participants begin to answer the four framing questions presented above, 2) if the format of the meeting was effective to achieve its goals and if it led to networking 3) whether plenary sessions and other large-group presentations encouraged participants to expand or renew their training curricula to include children’s oral health, and 4) participants’ assessment of the conference overall and their recommendations for next steps. These foci as they were reflected in the survey questions are described in further detail below. A copy of the evaluation survey is provided in the Appendix.

**1) Leadership.** Respondents were asked to rate the extent to which the conference stimulated their thinking about:

- a. The meaning of leadership in the MCH context and their own leadership trajectory
- b. Gaps and goals for faculty development to strengthen leadership training
- c. New ideas for leadership curricula or other training experiences
- d. Frameworks or strategies for short- and long-term assessment of trainees’ leadership development

**2) Conference format.** The conference was designed to encourage interdisciplinary discussion about leadership qualities, training experiences and unmet educational needs by mixing faculty

from the various MCHB leadership long-term training categories and sites. Questions that tapped aspects of networking and group processes revealed the extent to which:

- a. Small workgroup sessions facilitated thinking about leadership competencies and training in new ways
- b. The conference encouraged networking or collaboration with other sites or other training program categories

**3) New (or renewed) focus on children's oral health.** Because many of the invited speakers spoke from their perspectives as leaders in children's oral health, conference participants were informed of disparities in oral health status, disparities in access to preventive and treatment services, and the impending dental workforce crisis. Participants were asked about the effect of this content on their own training curricula. Specifically, whether, as a result of the conference, they would:

- a. Add or expand information about children's oral health concerns within their training program

**4) Overall assessment of the conference and recommended next steps.** Three open-ended questions asked about aspects of the conference that were the:

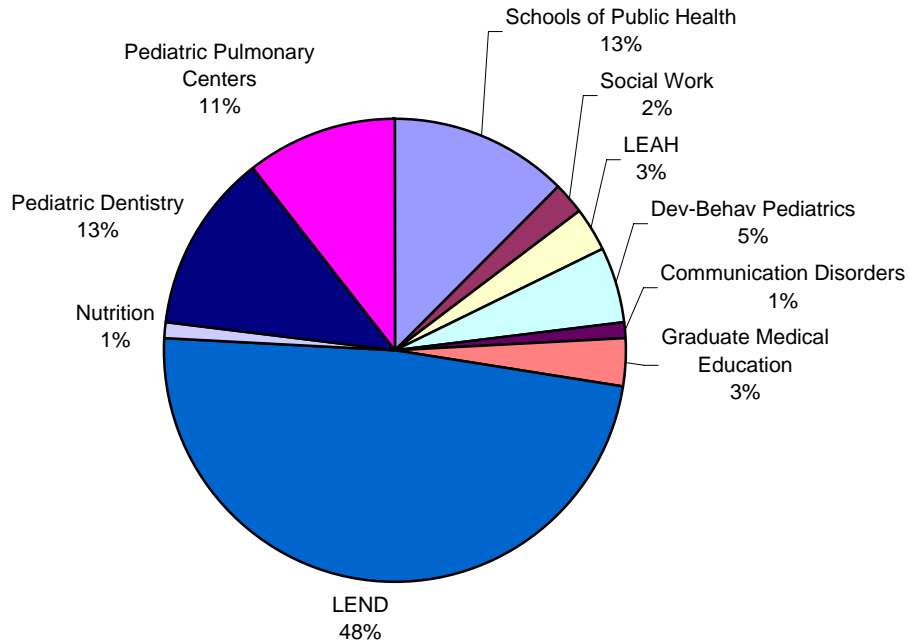
- a. Most valuable
- b. Least valuable
- c. Suggested next steps to strengthen MCH leadership development

## RESULTS

**Conference attendance.** A total of 120 people attend part or all of the two-day meeting. Participants were residents of 28 states that spanned the continental United States and included Hawaii. Of the 120 attendees, 95 were faculty of MCHB-funded long-term leadership training programs. Ten of the eleven training categories were represented. Due to a scheduling conflict with the all-grantee meeting for nursing, representatives of the MCHB-funded Leadership Education and Research in Nursing (LEARN) programs were unable to attend the Seattle meeting. Nursing, as an important discipline within MCH, was represented at the meeting through the participation of nurses from within interdisciplinary training programs including the LEND and Pediatric Pulmonary Center programs.

The distribution of individuals by training program category is presented in Figure 1 below. It corresponds, roughly, to the distribution of training programs nationwide. Nearly half the conference attendees associated with training programs were with LEND programs. Schools of public health (SPH), pediatric pulmonary centers (PPC) and pediatric dentistry (PD) were also well represented and slightly in excess of their frequency nationwide. Their strong showing partly reflects the participation of UW (Seattle) faculty from these program categories. Four MCH leadership training programs are located at the UW: SPH, PPC, PD and LEND. A second reason for heavy representation from pediatric dentistry was that this conference followed, at the same location, a meeting of the three MCHB-supported pediatric dentistry programs.

**Figure 1: Training Category Affiliation of Attendees**



**Evaluation survey response rate.** Of the 95 faculty of MCH long-term training programs who attended the conference, 60 completed the evaluation survey. The response rate of 63% is a conservative estimate. Evaluation surveys were distributed at the end of the second day of the conference. It is known by anecdote that several participants attended only the first day of the conference due to schedule conflicts and that others left early on the second day to make eastbound flights. The exact number of faculty on the premises at the time of the evaluation survey is not known; a total of 95 faculty registered and attended at least part of the meeting.

The remainder of this report refers to the responses provided by all 60 (of 95) faculty members. Omitted from the analysis of results were surveys completed by invited speakers, MCH Bureau personnel and other guests.

**Coding and data reduction.** Items that asked for ratings employed five-point Likert scales with responses that ranged from “1” indicating the conference was “not at all useful” to “5” denoting that the conference was highly effective for that particular question. In the analyses reported here, scores of 4 and 5 were combined to indicate a positive response. Percentages were used to summarize respondents’ opinions about three aspects of the conference: leadership, format for collaboration and networking, and children’s oral health as a topic for training. Responses to open-ended questions about the overall value of the conference and next steps were clustered by theme, tallied and reported as percentages. Not all respondents offered responses to the open-ended questions; very few respondents offered more than one opinion per question.

## 1) Leadership

**Definition of Leadership and Methods for Training:** The conference succeeded in deepening participants' understanding of MCH leadership and leadership training in general; 83% of respondents scored this item positively. In answer to more specific questions, respondents said the conference advanced their understanding of leadership on both the personal and professional levels. Three-fourths (76%) reported the conference stimulated personal reflection about their own leadership trajectory. Additionally, approximately 80% reported they were exposed to new ideas about leadership within the MCH context. Over half (56%) of respondents reported the conference introduced them to new approaches to mentoring trainees and nearly two-thirds (61%) reported they identified faculty development needs.

When asked for examples of potential effects of the conference on training program activities, over half (55%) of the respondents said it stimulated a new, or renewed, focus on faculty development and mentoring skills, 30% planned to revise their frameworks and training methods to reflect the leadership competencies discussed at the conference, and 17% planned to improve the transparency of their program's mission and goals. Several participants said they intended to increase the value of leadership among trainees by "formalizing the mentoring process."

**Assessment of Leadership Training:** Day two of the conference focused on possible approaches for evaluating MCH leadership training. The day began with a presentation on the Malcolm Baldrige Criteria for Performance Excellence followed by further discussion within the workgroups. Two-thirds (65%) of survey respondents reported the conference was highly effective at stimulating their thinking about approaches to evaluation. One-third planned to implement an outside assessment tool to evaluate their training programs, 20% reported they would consider Baldrige specifically, and 25% reported they planned to align their programs' missions and training goals before implementing an evaluation tool.

Attitudes towards using the Baldrige framework to guide continuous improvement and outcome evaluation of MCH training programs were generally positive. Two thirds (64%) of respondents reported the Baldrige approach provided useful ideas for program evaluation, 17% were neutral and 15% reported that the approach, as presented at the conference, did not seem relevant to MCH leadership training.

Survey respondents volunteered many comments that indicated assessment is an area of current attention and an area in which further discussion would be welcome. Comments also revealed a range of opinions about quality assessment for program improvement:

- *We need an outside, standardized assessment tool.*
- *We seriously looked at Baldrige but could not "afford" the new methodologies / measures to compete.*
- *I remain uneasy about two things 1) measures will be dictated and oppressive (too time consuming) and 2) measurements will be used against us. The time and budget pinch is already critical. More demands will push programs over the edge.*

## 2) Conference Format to Encourage Collaboration and Networking

The conference format alternated large-group presentations with 11 small workgroups. Each workgroup was assigned to focus on one competency area over the course of the two-day meeting. Workgroup assignments were made prior to the meeting based on participants' interests and to assure broad representation of training categories within each group. The purpose was to encourage discussion and networking among faculty across training categories and in the various training locations. Most participants took advantage of the opportunity to do just that. Among survey respondents, 73% said the conference "engaged me in new or expanded networking or collaboration with different MCH long-term training programs within my institution" or "with different MCH training programs (of a different discipline) in other institutions.

Forty-four percent of respondents said the workgroups provided excellent discussions that advanced their understanding of MCH long-term leadership training programs, including their own. Participants described the workgroups as "intense," "overly ambitious for the time allotted" and "the real work of the conference." This view was emphasized further by those who said, for example,

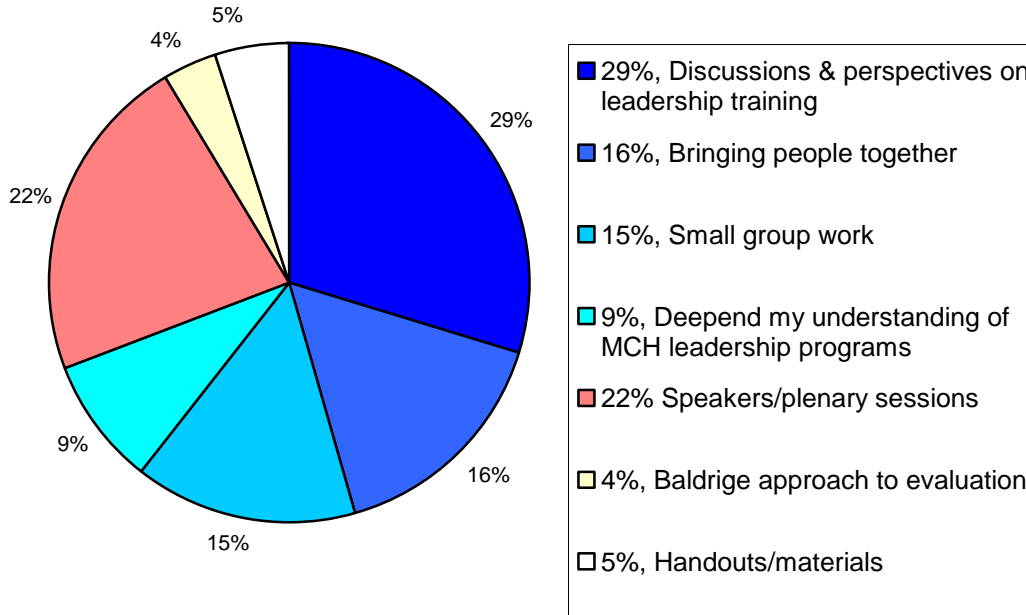
- *It was enlightening to exchange views and see how others perceive my domain.*
- *This may have been the richest part of the event. The group functioned like a team that had been together for years.*

**Oral Health:** Examples from MCH oral health were used by many of the featured speakers to illustrate opportunities, challenges and successes of leadership. Although these sessions were not intended as didactic or prescriptive, nevertheless, more than half the survey respondents (53%) reported they planned to integrate oral health into their training programs in new or expanded ways.

Dental professionals in attendance were asked to identify which MCH leadership competencies they planned to integrate into their training program as a result of the conference. Six dental professionals responded to this question. The most common responses were: public health, followed by ethics and professionalism, an interdisciplinary view of health and well-being, family involvement with health services, cultural competency, and medical or developmental issues.

**Overall Assessment of the Conference:** Open-ended questions provided an opportunity to report overall impressions of the conference. When asked what was the most valuable aspect of the conference, 69% described the opportunities to reflect or deepen their thinking about MCH leadership. Some offered global comments while others commented on the method by which this was achieved. The importance of personal connection came up repeatedly among the majority of participants who identified discussion, bringing people together and small group work as the most valuable aspects of the conference (60%). Additionally, 22% of respondents identified plenary speakers as most valuable aspect of the conference (see Figure 2 below).

**Figure 2: Most Valuable Aspects of the Conference  
(n = 59)**



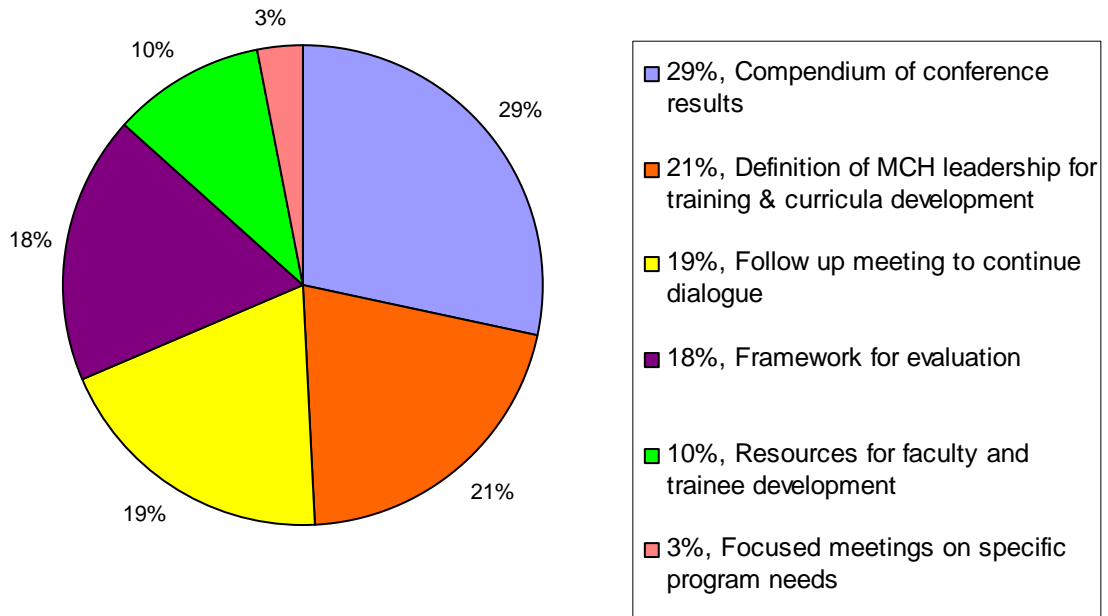
When asked about the least valuable aspect of the conference, mixed opinions of the Baldrige approach became apparent. While 24% of participants reported they planned to consider its application to their training program, 19% (n = 33) reported discussion of the Baldrige approach to MCH training was the least valuable aspect of this conference. Eighteen percent noted time constraints as a weakness of the conference. Approximately 15% were dissatisfied with the small workgroups and an approximately equal number (15%) felt there were too many “didactic” (plenary?) sessions. Twelve percent were disappointed by the lack of any specific criteria or direction for how to develop leadership within the training programs.

**Recommendations:** A final question asked “what would you like to see most in the next steps and follow up?” Forty-nine participants responded to this question; most made a single suggestion. Taken together, the responses corroborate the recommendations set forth earlier in this report (see Figure 3 below).

The most common suggestion for follow-up action was to create a compendium of the output and recommendations of the workgroups (29%) as provided by this report. Nineteen percent of survey respondents recommended a follow-up conference to continue dialogue about leadership competencies. A nearly equal number (21%) made a similar suggestion; they recommended continued progress toward establishing a definition of MCH leadership and criteria for training (19%). The next opportunity to do so is now planned as part of the October 3 - 6, 2004 HRSA/MCHB All Grantee Meeting in Arlington, VA.

Other recommendations for next steps included the need for a framework to evaluate MCH long-term leadership training programs (18%) and to develop additional resources for faculty development as well as that of the trainees (10%). Two people noted that the range of training needs identified at the meeting might be met most efficiently by creating focused meetings or training modules on individual leadership competencies or other specific program needs.

**Figure 3: Recommendations for Follow Up**  
(n = 49)



## **APPENDIX**

- **List of MCH training categories**
- **Work group members**
- **Work group instructions**
- **Evaluation form**
- **Conference participants**
- **Background reading (not included in the electronic version of the report)**

## **List of Long Term MCH Training Categories**

1. Leadership Education in Adolescent Health (LEAH)
2. Developmental-Behavioral Pediatrics
3. Communication Disorders
4. Graduate Medical Education and Summer Mentor Program  
(formerly Historically Black Colleges)
5. Interdisciplinary Leadership Education in Neurodevelopmental  
and Related Disabilities (LEND)
6. Nursing (not represented at this conference)
7. Nutrition
8. Pediatric Dentistry
9. Pediatric Pulmonary Centers (PPC)
10. Schools of Public Health (SPH)
11. Social Work

## **Workgroup Members**

(by original conference workgroup number)

### **1. Communication**

- Jean Emans (Co-Facilitator), LEAH
- Colleen Huebner (Co-Facilitator), Public Health
- Mary Marcus (Co-Facilitator), PPC
- Marilyn Hartzell, LEND
- Elisabeth Luder, PPC
- Lisa Hoeft Albers, Developmental Behavioral Pediatrics
- Amy Richards, Trainee: LEND
- Jim Boggs, Private: Effective Arts, Seattle

### **2. Constituency Building**

- Wendy Mouradian (Co-Facilitator), Pediatric Dentistry
- Rocio Quinonez (Co-Facilitator)
- Dominick DePaola (Co-Facilitator), Forsyth Institute
- Katrina Holt, Pediatric Dentistry
- Lynn Levin, LEND
- Jeffrey Okamoto, LEND
- Cordelia Robinson, LEND
- Dennis Stevens, LEND
- Anne Hopewell, HSR – Regional Oral Health Forums

### **3. Cultural Competency**

- Noel Chavez (Co-Facilitator), Public Health
- Sally Stuart (Co-Facilitator), LEND
- Maxine Hayes, MCH leader: WA State Dept of Health
- Brooke Carroll, LEND
- Elisabeth Ceysens, LEND
- Dan Doherty, LEND
- Ryon Jolley, Public Health
- Diane Magyary, Nursing
- Roz Parrish, LEND
- Carolyn Richardson, LEND
- Tokesha Warner, MIND
- Rosemary DePaola, Nursing

### **4. Mentoring**

- Louise Iwaishi (Co-Facilitator), LEND
- Jane Rees (Co-Facilitator), Public Health
- Richard Burke, Pediatric Dentistry
- Jeannine Coreil, Public Health
- Edward Hills, OB
- Shelley Mulligan, LEND
- Mary Jane Rapport, LEND

#### **4. Mentoring con't**

- Doug Shaad, Pediatric Dentistry
- Susan Swanson, Shriver Center

#### **5. Negotiation / Conflict Resolution**

- Penelope Leggott (Co-Facilitator), Pediatric Dentistry
- Rebecca Slayton (Co-Facilitator), Pediatric Dentistry
- Daniel Armstrong, LEND
- Jan Dodds, Nutrition
- Roland Ellis, LEND
- Alice Tse, LEND
- Anne Heintzelman, LEND
- Michele Issel, Public Health
- Mary Schroth, PPC

#### **6. Evidence Base / Science Translation**

- John McLaughlin (Co-Facilitator), LEND
- Peter Blasco (Co-Facilitator), LEND
- Jessica Lee, Pediatric Dentistry
- Kathleen Braden, LEND
- Charlene Trovato, Behavioral Pediatrics
- Erica Monasterio, LEAH
- Catherine McCain, LEND
- Steven Levy, Pediatric Dentistry
- Wendy Hellerstedt, Public Health

#### **7. Policy / Advocacy**

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- Bruce Shapiro (Co-Facilitator), LEND
- Nathan Blum, Behavioral Pediatrics
- Michele Gains, LA Mentor Program
- Carrie Griffin, LEND
- James Hagood, PPC
- Mike Kanellis, Pediatric Dentistry
- Virginia Reed, LEND
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- Steven Viehweg, LEND

#### **8. & 9. Management & Working with Organizations**

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- Erica Okada (Co-Facilitator), UW School of Business
- Cynthia Ellis, LEND
- Susan Horky, PPC
- Faye Untalan, Public Health
- David Schonfeld, Behavioral Pediatrics
- Suzanne Pearson, LEND
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- Gail Kieckhefer (Co-Facilitator), UW School of Nursing
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- Crystal Clement, LEND/AUCD
- Lee Dibble, LEND
- Erin Olson, LEND
- Ed Pecukonis, Social Work
- Kathy TeKolste, LEND
- Sharine Thenard, Pediatric Dentistry

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- Kathleen Rounds (Co-Facilitator), Social Work
- Joann Bodurtha, LEND
- Dennis Harper, LEND
- Judith Holt, LEND
- Ronald Matayoshi, Social Work
- Diane Smith, LEND
- Bill Vann, Pediatric Dentistry

## **12. Ethics / Professionalism**

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- Lynne Robins (Co-Facilitator), Medical Education/ UW Teaching Scholars program
- Gregory Boris, LEND
- Katrina Carmichael, LA Mentor Program
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- Ellen Daley, Public Health
- Glen Deere, LEND
- John Rau, LEND
- Kathleen Shelton, LEND

## WORK GROUP INSTRUCTIONS

### Pre-conference Assignment:

#### Instructions

1. **Identify the workgroup to which you have been assigned from the emailed grid.**
2. **Please complete the Pre-Conference Assignment below and bring with you.**
3. **Be prepared to share your experience during the 1<sup>st</sup> Work Group Session.**
4. **Optional: Turn this worksheet in to conference organizers**

▪ Describe one personal experience that required leadership in the domain assigned to your work group. (For example, you needed to **build a constituency** to create a new program in your community or institution)

▪ Identify the key skills or competencies you needed to be successful in the example you provided (For example, you needed to **listen** carefully to all parties, **re-frame** the issues for disparate groups, and impart **a sense of optimism** through difficult negotiations)

▪ Identify training or practical experiences you received (or wished you had received) to develop these leadership skills or competences.

- Is this skill important for future MCH leaders?

**Name**

**Degrees**

**Program Category**

**Institution / Location**

## **MCH Working Conference:**

Instructions for Work Group Session # 1 DAY ONE

**Monday April 19, 2004 11:45 – 2:00 PM**

Skills, Competencies, and Domains

### **The session objectives are:**

1. Identify and prioritize cross-cutting skills / competencies associated with this domain
2. Identify training experiences that support development of these skills
3. Refine / define this domain

### **Individual Work (to be completed in advance)**

- Describe one personal experience that required leadership in the domain assigned to your work group.
- Identify the key skills or competencies you needed to be successful in the example you provided.
- Identify training or practical experiences you received (or wished you had received) to develop these leadership skills or competences.
- Is this skill important for future MCH leaders?

### **Instructions/ suggested schedule for Work Group Session # 1:**

1. As a way of getting to know each other and beginning the work of this group, share your leadership experience with others assigned to this workgroup domain (11:45-12:30pm).
2. As a group, use these experiences to identify essential aspects of this leadership domain (12:30 – 1:30pm).
3. Is the given label (e.g., communication, constituency-building) the best label for this domain? If not, propose a better term (1:30 – 2:00 pm).

### **Summary of Questions for Discussion:**

1. What are the **most important skills / competencies / qualities** for this leadership domain?
2. Are these **cross-cutting skills – ie,** needed for all MCH training program categories?
3. What **training experiences** help develop skills/competencies in this domain?
4. Will these be the same for **future MCH leaders?**
5. Refine, **label or define the domain** succinctly. Is it essential for MCH leaders?

### **The Recorder:**

Complete attached Worksheets # 1A and 1B and return to conference organizers.

## Worksheet # 1 A: Notes of Shared Experiences of Participants

Leadership Domain: _____		
1	<u>Shared experience (brief)</u>	<u>Leadership skills, competencies, qualities needed</u>
2	<u>Shared experience</u>	<u>Leadership skills, competencies, qualities needed</u>
3	<u>Shared experience</u>	<u>Leadership skills, competencies, qualities needed</u>
4	<u>Shared experience</u>	<u>Leadership skills, competencies, qualities needed</u>
5	<u>Shared experience</u>	<u>Leadership skills, competencies, qualities needed</u>
6	<u>Shared experience</u>	<u>Leadership skills, competencies, qualities needed</u>

**Worksheet # 1B: Recorder’s Summary for Report at Plenary Session (2:15 – 3:15pm)**

**Leadership Domain:** \_\_\_\_\_  
 (Assigned Work Group Name if different than above label: \_\_\_\_\_)

	<p align="center"><b>Priority Skills / Competencies / Qualities for this Leadership Domain and Training Experiences to Develop Them</b></p>
	<p>Skills (list as many as identified)</p> <p>_____</p> <p>_____</p> <p>Training experiences (to match skills)</p> <p>_____</p> <p>_____</p> <p>_____</p>
	<p>Final (succinct) Label of Domain</p> <p>_____</p> <p>Final (succinct) Definition / Statement Describing Domain:</p> <p>_____</p> <p>_____</p> <p>_____</p>
	<p>Is this domain essential for MCH leaders of the future?</p>
	<p>Additional Comments</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

## MCH Working Conference:

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Instructions for Work Group Session # 2 DAY TWO

Tuesday, April 20, 2004 9:30 am - 10:30 am

### Measurement and Evaluation

#### The session objectives are:

- To propose measurement frameworks or methods of evaluating leadership curricula, or leadership-building experiences, in your assigned leadership domain.
- To propose measurement frameworks or methods for evaluating short- and long-term outcomes of MCH leadership training overall (if time allows).

\*\*Added at the conference: Describe what a MCH leader looks like practicing this particular competency.

#### Instructions for the Group

**Work group members review the objectives for this session. The group facilitators review, with the group, the final list of priority skills and trainee competencies identified during yesterday's Work Group Session #1.**

**Using the measurement frameworks presented in the plenary sessions and other approaches to outcome evaluation, the group discusses:**

#### Questions for Discussion:

1) What strategies or methods exist to evaluate the skills or competencies associated with your assigned leadership domain?

Specify how indicators of leadership in this domain might differ:

- a) Among trainees within the training program or up to one year of its completion
- b) Five years following program completion
- c) Ten years out?

2) [if time allows] Are there other strategies, methods or definitions that can help us evaluate long-term training outcomes more generally (e.g., that trainees achieve a community or professional role or other personal accomplishments)?

**For the Recorder:** Complete attached Worksheet #2 and return to Conference organizers.

**Worksheet # 2 for DAY TWO:  
Recorder's Summary: Report at Plenary Session (10:30 – 11:30 am)**

<b>Leadership Domain:</b> _____		
(Assigned Work Group Name if different than above label: _____)		
1	Skill or Competency	<u>Strategy/Method to Assess Skill or Competency</u>
2	Skill or Competency	<u>Strategy/Method to Assess Skill or Competency</u>
3	Skill or Competency	<u>Strategy/Method to Assess Skill or Competency</u>
4	Skill or Competency	<u>Strategy/Method to Assess Skill or Competency</u>
5	Skill or Competency	<u>Strategy/Method to Assess Skill or Competency</u>

Indicators of MCH Leadership (Overall):

**MCH Working Conference:**  
**The Future of Maternal & Child Health Leadership Training**  
**April 19-20, 2004 `Seattle, Washington**  
**CONFERENCE EVALUATION**

Please indicate how engaging you found the conference with respect to the following items:

**A. Leadership:**

This conference

1. deepened my understanding of leadership in the MCH training context  
**1 (not at all)    2    3    4    5 (really got me thinking)**
2. provided me with new ideas for leadership curricula or experiences within my MCH program  
**1 (not at all)    2    3    4    5 (really got me thinking)**

**B. Evaluation and outcomes:**

1. This conference provided me with new information/approaches for evaluating my program  
**1 (not at all)    2    3    4    5 (really got me thinking)**
  2. Presentation of the Baldrige approach provided useful ideas for evaluating my program  
**1 (not at all)    2    3    4    5 (really got me thinking)**
  3. List one idea you will apply to your program: \_\_\_\_\_
- 

**C. Personal leadership issues:**

This conference

1. stimulated personal reflection about my own leadership trajectory  
**1 (not at all)    2    3    4    5 (really got me thinking)**
  2. introduced me to new approaches for mentoring/teaching trainees  
**1 (not at all)    2    3    4    5 (really got me thinking)**
  3. helped me to identify faculty development needs  
**1 (not at all)    2    3    4    5 (really got me thinking)**
  4. List one idea you will apply in your program: \_\_\_\_\_
- 

**D. Collaboration and networking:**

This conference engaged me in new or expanded networking/collaboration with

1. different MCH leadership programs within my institution  
**1 (not at all)    2    3    4    5 (definitely)**
2. similar MCH leadership programs in other institutions





## **MCH Working Conference**

### **The Future of Maternal & Child Health Leadership Training**

**Seattle, WA**

**April 19-20, 2004**

#### **Participant List**

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