

**DRAFT Report from the MCH Working Conference:  
The Future of Maternal and Child Health Leadership  
Training**

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**Prepared by**

**Colleen E. Huebner, PhD, MPH, Conference Co-chair  
Director, MCH Leadership Training Program  
School of Public Health and Community Medicine**

**Wendy E. Mouradian, MD, MS, Conference Co-chair  
Associate Director, MCH Leadership Education in Pediatric Dentistry  
School of Dentistry**

**University of Washington**

## 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 Program of the University of Washington (UW) School of Public Health and Community Medicine, the Center for Leadership Education in Pediatric Dentistry in the UW School of Dentistry. The Conference was funded by the Maternal and Child Health Bureau, 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 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). These 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 cross-cutting definition of MCH leadership.

We recommend faculty development and 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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*REPORT DRAFT MCH Working Conference On Leadership Training*

## Acknowledgements

*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 and 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; and our tireless and cheerful Project Staff Carmen Velasquez and Cheryl Shaul. 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 1987-88 MCH Leadership Training Conference were able to attend to provide perspective 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.

Colleen E. Huebner, PhD, MPH

Wendy E. Mouradian, MD, MS

**Planning Committee**  
(and Workgroup Facilitators)

Colleen Huebner, Co-Chair (Communication)  
Wendy Mouradian, Co-Chair (Constituency Building)

Greg Alexander  
Marion Taylor Baer  
Joel Berg (Management / Organizations)  
Peter Blasco (Evidence Base/ Sci. Translation)  
Noel Chavez (Cultural Competency)  
Col. Ellen Davis  
Jean Emans (Communication)  
Louise Iwaishi (Mentoring)  
George Jesien  
Laura Kavanagh  
Col. Patrick Kelly  
Penelope Leggott (Negotiation and Conflict Resolution)  
Lew Margolis (Policy and Advocacy)  
John McLaughlin (Evidence Base/ Sci. Translation)  
Roz Parrish (1987-88 Workshop participant)  
Greg Redding (Critical Thinking)  
Mary Richardson (1987-88 Workshop participant)  
Lynne Robins (Ethics / Professionalism)  
Angela Rosenberg (Internal Process)  
Kathleen Rounds (Critical Thinking)  
Doug Schaad (Mentoring)  
Bruce Shapiro (Policy and Advocacy; 1987-88 Workshop participant)  
William Walker  
Margaret West (1987-88 Workshop participant)

**Additional work group facilitators**

Jane Rees (Mentoring)  
Rebecca Slayton (Negotiation and Conflict Resolution)  
Sally Stuart (Cultural Competency)  
Gail Kieckhefer (Internal Process)  
David Nash (Ethics/Professionalism)  
Dominick DePaola (Constituency Building)  
Rocio Quinonez (Constituency Building)  
Erica Okada (Management / Organizations)

## INTRODUCTION

**Purpose:** This Conference began as an outreach activity of the University of Washington 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 MCH Program of 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 leadership training 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.

**Work Group Assignments:** To help stimulate thinking about leadership competencies in advance of the Conference, attendees were assigned to one of 12 work groups, 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, work groups 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, work groups were asked to define or further refine each competency, and to describe how a mature MCH leader might demonstrate this competency. Although few work groups were able to complete all these tasks, the discussions that ensued were enormously rich and varied. (See Appendix for listing of work groups 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. Several participants from these workshops helped 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/1987confrpt.pdf>

**Preparation of this Report.** This Report was prepared utilizing a variety of sources, including transcripts from Conference plenary sessions, verbal summaries from the different work groups,<sup>2</sup> speakers' power-point presentations, written summaries and notes from work groups. 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 the specific MCH leadership competencies we went beyond discussions of the work group assigned to that particular competency, and considered relevant deliberations in other work groups, plenary sessions, and in some cases, the literature. From this synthesis, we propose an overall definition of MCH leadership. Because all work groups could not fully explore training experiences and outcomes assessments for the competency areas in the time allotted, we consider these in general terms, with some attention to faculty development as well.

We have not attempted to summarize every aspect of leadership and leadership training discussed at the Conference, rather we tried to integrate and synthesize 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 summaries forwarded to us from the individual work groups have also 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 and Leadership Training**

**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 a 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 Conference on MCH 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, life experiences and 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 1987-88 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.

### **DEFINITION OF MCH LEADERSHIP**

***Proposed definition:** 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 leadership competencies (including those of the Association of Teachers of Maternal and Child

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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>

Health). Over the course of the conference, none of the proposed competencies 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 these competencies into primary (or core) competencies and applied (or secondary) competencies. Primary or 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 (or primary) competencies include:

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

Secondary competencies involve the application of core competencies to more complex situations and tasks faced by MCH leaders. They typically require additional training. The teachable aspects of both types of competencies (core and applied) have implications for training programs and leadership curricula. The secondary “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.** Based on work group discussions and Conference interactions we sub-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 work group discussions was shared MCH “values,” as outlined in “Principles for the Organization of MCH Systems and Services,” from the MCHB Strategic Plan for 2003-7.<sup>4</sup> These include an emphasis on evidence-based practices; a population-based focus; family-centered, culturally competent, community-based services and systems; an interdisciplinary perspective; prevention-orientation and focus on vulnerable populations. Evidence-based approaches and cultural competency were addressed in specific

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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

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

Competency Name (Original conference workgroup number in parentheses)	Type: Core or Application
<b>0. <sup>A</sup> MCH background/ Public Health</b>	<b>Background</b>
<b>1. Communication Skills (1)</b>	<b>Core</b>
<b>2. Critical Thinking (11)</b>	<b>Core</b>
<b>3. Internal Process/ Self-reflection (10)</b>	<b>Core</b>
<b>4. <sup>B</sup> Ethics / Professionalism (12)</b> a. Moral purpose (MCH mission/vision) b. Moral compass (professionalism) c. Ethical knowledge/skills	<b>Core</b>  <b>Core 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, Working with Organizations (8/9)	Applied
11. Constituency Building (2)	Applied
12. Policy and Advocacy (7)	Applied

Table I outlines the original leadership competencies assigned to work groups. These have now been grouped into 2 broad categories based on Conference discussions and analysis. “Primary” or 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. 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.

work groups. 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—ie, 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 a much more complex process. These 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 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 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.

**Specific group recommendations.** Some groups 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 from the work groups was to emphasize case-based training, story-telling, 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 and 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 multiple competencies and demonstrate learning in these areas simultaneously. These are

discussed further below in the 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” or 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 specifically: interpersonal and communication skills, self-motivation, flexible and adaptable thinking and temperament, and maturity; 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 on how to identify core qualities in trainees and assess usefulness of selection criteria.

**Implications for faculty development.** The training agenda that might emerge from the MCH competencies proposed has obvious implications for faculty development and many groups identified the need for faculty training. 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) with a summary of approaches to course development, learning objectives/ testing, 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 video-taping to debrief cases, patient-interviews, focus groups or presentations. The goal of these kind of 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, etc). 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 current abilities in these arenas.

**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 for a tomorrow we can not know. Rapidly advancing science and technologies, shifting demographics, global political, economic and social forces will only accelerate future changes in the MCH environment. The 1987-88 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 group, the interdisciplinary MCH 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 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 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 is 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

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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

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 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 MCHB Long-Term 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 the MCH Bureau's vision and mission and the tension that arises when this goal differs from specific institutions' (e.g., University, clinical training sites) expectations of faculty and trainees.

Nonetheless, training program activities needs and products need to aligned with the intent and aim of the Bureau. A new mission and goals statement for MCH Leadership Training programs was drafted recently. This, in addition to the overall mission 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 in 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 Leadership 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 the 2004 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 be, or will become, well-placed to assume leadership roles in various settings including local, state or federal government, 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 for 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 vs. relatively new leaders. It follows that evaluation of trainees’ success during and upon graduation should be tailored both to their career goals and stage 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.** The workgroups used a competency framework to discuss and organize recommendations for training experiences. Linking outcome evaluations with these competencies 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 also be obtained through self-assessments. 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 may 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. Example of skills taught within some training program represented at the Conference include: grant writing, development of a strategic plan, running meetings and case conferences, assisting in policy development, and evaluating and revising health education materials and practices to assure 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 would 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, etc), 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 experience that call together multiple, relevant leadership and discipline-specific competencies to address a relatively novel, concrete task could be created for each training program category (e.g., public health, nursing, LEND, pediatric dentistry, pediatric pulmonary programs, etc). The thesis research of the MPH is perhaps the most full-blown example; examples within clinical programs might include creating an adolescent health education 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 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

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6 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.

7 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.

8

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

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

link between the Training Program and the MCH Block Grant Program.

**Collaboration and partnership as a leadership training outcome.** At the Conference, Dr. Virginia Reed presented her qualitative research analyzing 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’ work because of its interdisciplinary nature. Conference workgroups also discussed collaboration, though 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 (“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 Training Program.

### **Conceptual Model: The Role of Training in the Trajectory of MCH Leadership**

The conference materials and ensuing conversations lead us to articulate a simple conceptual model for MCH leadership and leadership training that is cross-disciplinary and leads to testable hypotheses. The model begins with intrinsic capacities that should be present in trainee applicants regardless of disciplines. At a minimum these should include: communication skills, critical thinking skills, capacity for internal reflection and a sense of ethics/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 are also cultivated within the training programs, 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, these skills are further honed 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 the 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 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, other agencies, 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 disseminating 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 proposed definition of MCH leadership and competencies from:
  - a. MCH leadership training programs not present at this initial working conference
  - b. Trainees and graduates of MCH Leadership Training Programs
  - c. Program categories
  - d. Families / patients
  - 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
3. **Develop a plan for faculty development to increase leadership training capacity:**
  - a. Develop 2-3 new CE opportunities per year for MCH faculty, by contract or competitive applications, based on the MCH 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 / 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 / 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 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 the multiple leadership competencies and their overlap (as depicted in Table I) capstone experiences can 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 programs and to 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 teaching and technical assistance.

## **SAMPLE 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 (ability take another's emotional perspective) and the ability to establish rapport and trust. To these ends the MCH leader must be sensitive to the cues of self and others (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 is possible. The MCH leader respects and values input of others, appreciates the necessity for multiple perspectives, and realizes the importance of building and sustaining relationships to accomplish change for MCH populations. The MCH leader is willing to share him or her-self 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 could 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 human and moral issues at stake

## 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 MCH mission and goals. Constituency building is a critical task of MCH leadership, since change in maternal and child health always requires interdisciplinary, cross-sector collaboration. The MCH constituency-builder moves an agenda forward in conjunction with others, can play role of leader / participant as needed and delegates authority to others appropriately. Constituency-building utilizes most of the other MCH competencies and skills being considered.

**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 they may be more energy and time-consuming. Accepts that the coalition builder may make mistakes (eg, s/he may leave out important stakeholders); is willing to apologize, 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 mission/vision for different audiences, understanding their different cultures, perspectives, use of language (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 longer time that may be required to move collaborative agendas forward
- Continually assesses the environment for pitfalls and opportunities that will affect the coalition 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

## **MCH Working Conference:**

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

**April 19-20, 2004**

**University Tower Hotel, Seattle, Washington**

### **CONFERENCE AGENDA**

#### **Monday, April 19, 2004**

- |                 |  |
|-----------------|--|
| 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</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</li></ul>  |
| 8:15 – 8:30 am  | Looking Back: Summary of 1987, 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 Health Training Program, School of Public Health and Community Medicine, University of Washington</li></ul> 1987, 1988 Conference members <ul style="list-style-type: none"><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>, University of Washington</li></ul> |
| 8:30 – 9:15 am  | Looking Forward: Leadership in the Public Good<br>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 | Defining Leadership for the Future: Concepts and Definitions of  |

## Leadership in Different Professional Settings

Discussants:

- **Wendy Mouradian, MD, MS**
- **Greg Redding, MD**, Professor of Pediatrics and Director, Leadership Education in Pediatric Pulmonary, University of Washington

9:30 – 11:15 am

Panel:

- **Bruder Stapleton, MD**, Chair, Department of Pediatrics, University of Washington – *representing education*
- **Joel Berg, DDS, MS**, Chair, Department of Pediatric Dentistry, University of Washington, former Vice President for Scientific Affairs, Philips Oral Health Care – *representing business*
- **Tracy E. Garland**, President and CEO, Washington Dental Service Foundation – *representing foundations*
- **Maxine Hayes, MD, MPH**, State Health Officer of Washington, Community and Family Health – *representing government*

11:15 – 11:30 am

Framing the Charge for Workgroups:

Explore 12 competencies and training experiences needed

11:30 – 11:45 am

Break

11:45 – 2:00 pm

Lunch and Twelve Breakout Groups for Domains, Competencies and Skills (sessions described below)

2:00 - 2:15 pm

Break – return to large group meeting room (Ballroom)

2:15 - 3:15 pm

Reports from Work Groups (5 minutes each)

- **Jeff McLaughlin, MD**, Professor of Pediatrics and Director, LEND, University of Washington
- **Wendy Mouradian, MD, MS**

3:15 - 4:45 pm

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

- **M. Ann Drum, DDS, MPH**, Director, Division of Research, Training and Education, Maternal and Child Health Bureau
- **Laura Kavanagh, MPP**, Training Branch Chief, MCH Training Program, Maternal and Child Health Bureau
- **Virginia Reed, PhD, MSN**, Research Associate Professor, Dartmouth Medical School
- **Angela Rosenberg, PT, DPH**, Center for Development and Learning, University of North Carolina at Chapel Hill

- 5:00 pm Conference day ends
- 6:30 - 7:00 pm No-Host bar and networking
- 7:00 - 8:30 pm Dinner/Invited Speaker  
Ethics, Public Health and Leadership
- **David Nash, DMD, MS, EdD**, Professor of Pediatric Dentistry and Bioethics, University of Kentucky Medical Center

## 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  
Discussants:
- **Colleen Huebner, PhD, MPH** and **Joel Berg, DDS, MS**
- Panel:
- **Virginia Reed, PhD, MSN**, Research Associate Professor, Dartmouth Medical School
  - **Judy Morton, PhD**, Vice President, Quality Integration and Improvement, Swedish Hospital, Seattle, and Baldrige Examiner
  - **Greg Redding, MD**, Professor of Pediatrics and Director, Leadership Education in Pediatric Pulmonary, University of Washington
- 9:00 - 9:15 am Charge to work groups: 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 Work groups to discuss measurement and evaluation (Registrants will receive specific instructions related to session discussion format before the conference.)
- 10:30 – 11:30 am Workgroup Report and Open Session  
Wrap Up: Summary of Recommendations

- **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 Work Group in Ballroom **Work**

## **Group Members**

### **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. 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

### **3. 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

### **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
- Susan Swanson, Shriver Center

## **5. Negotiation and 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 Heintzeman, LEND
- Michele Issel, Public Health
- Mary Schroth, PPC

## **6. Evidence Base and 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 and Advocacy**

- Lew Margolis (Co-Facilitator), Public Health
- 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
- Anne Tharpe, Communication Disorders
- Steven Viehweg, LEND

## **8/9. Management and Working with Organizations**

- Joel Berg, (Co-Facilitator), Pediatric Dentistry
- 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

- Lisa Samson Fang, LEND

#### **10. Internal Process / Self-reflection**

- Angela Rosenberg (Co-Facilitator), LEND
- Gail Kieckhefer (Co-Facilitator), UW School of Nursing
- L. Francine Caffey, PPCC
- Crystal Clement, LEND/AUCD
- Lee Dibble, LEND
- Erin Olson, LEND
- Ed Pecukonis, Social Work
- Kathy TeKolste, LEND
- Sharine Thenard, Pediatric Dentistry

#### **11. Critical Thinking**

- Greg Redding (Co-Facilitator), PPC
- 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 and Professionalism**

- David Nash (Co-Facilitator), U Kentucky, Pediatric Dentistry/Ethics
- Lynne Robins (Co-Facilitator), Medical Education/ UW Teaching Scholars program
- Gregory Boris, LEND
- Katrina Carmichael, LA Mentor Program
- Kay Conklin, Leadership Education
- Ellen Daley, Public Health
- Glen Deere, LEND
- Milton Kotelchuck, Public Health
- John Rau, LEND
- Kathleen Shelton, LEND