LEADERSHIP TRAINING: THE REPORT OF TWO MCH-SPONSORED WORKSHOPS

LEADERSHIP TRAINING I

Conference Report

The report of a conference on leadership training in Maternal and Child Health-funded training programs.

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PREFACE

The document is the product of a conference on leadership training in training programs funded by the Division of Maternal and Child Health (MCH). Representatives of seven categories of MCH training programs met at Ft. Mitchell, Kentucky, in September, 1987, to discuss leadership training. The idea for the conference was implicit in the 1962 President's Panel on Mental Retardation, from whose report emerged the concept of the interdisciplinary training of "seed personnel" to influence training in the mental retardation field by university affiliated facilities. Other MCH training programs have also had long-standing mandates to provide leadership training. However, what leadership training is, how it is done, and how it is evaluated were questions that had not been directly considered in any of the MCH training efforts.

In 1985, a planing committee of the American Association of University Affiliated Programs' Training Directors' Council met to formulate a proposal to present to MCH for a leadership conference. The purpose of the conference was to develop ideas for facilitating programmatic changes that would focus on leadership training. Suggested content areas included a functional definition of leadership, the characteristics of leaders, the selection and training of students, and the evaluation of training strategies.

The proposal was funded early in 1987 and a small working conference convened, with representatives from behavioral pediatrics, pediatric pulmonary centers, adolescent health training programs, schools of public health, state MCH-Crippled Children's directors, and MCH-funded intradisciplinary training programs, as well as from university affiliated facilities. The participants initially followed the carefully-planned agenda. They soon realized that the topic was so dynamic and the participants so committed that they required a new agenda, which came into being during the course of the proceedings. The dominant characteristic of the conference was the realization that leadership training was essentially a developmental process; the conference reached a satisfactory stage that allowed a comprehensive summation of the issues and a series of recommendations.

Here, then, is the product of the efforts of the conference participants and their ideas as to future directions.

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CHAPTER ONE:

OVERVIEW OF LEADERSHIP TRAINING

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Training leaders is a fundamental goal of the Division of Maternal and Child Health (MCH). As a result of supporting preservice and inservice training throughout the country, MCH has been instrumental in the development of leaders representing many disciplines and holding a variety of positions that are key to the organization and delivery of a broad range of health and social services to children, adolescents, and their families. MCH sponsors training through university affiliated facilities (UAFs), adolescent health training projects, maternal and child health training in schools of public health, and pediatric pulmonary centers, for example. Professionals trained in these programs provide significant leadership in the fields of child development, mental retardation and developmental disabilities, and other handicapping conditions of childhood and adolescence.

Graduates of MCH-sponsored training activities can achieve two types of leadership status. First, as a result of outstanding performance within their discipline, graduates often achieve a high level of professional regard and are considered leaders within their communities. Their leadership results from their knowledge and professional performance capabilities and may not be related to positions of authority within an organization. However, their success may make them likely candidates for such positions. These people are often asked to serve on community boards, advisory committees, or government task forces.

Second, graduates are viewed as leaders because they hold positions of authority within agencies or organizations. Their selection for these administrative and management positions may result from additional training in management science or education, health care, or public administration. Selection also may result from the individual's clinical expertise and the professional acclaim received in a particular discipline. Both administrative and management leadership positions require training that takes into account the need for clinical excellence in the field of maternal and child health, and training which recognizes that education administration, health care administration, public health administration, and management science are disciplines in and of themselves.

Currently, MCH preservice programs focus on clinical training, and the graduates usually achieve leadership status and promotional recognition for their outstanding professional contributions. Management and administration, as separate disciplines, are recognized in varying degrees in MCH training programs across the country, but such training efforts account

for only a very small amount of the overall training initiative. The remainder of this chapter will define leadership and discuss the implications for leadership training.

What is Leadership?

Leadership is frequently defined as a process in which one person influences other individuals in their attainment of a common goal (Stogdill, 1974; Lord, 1977). Hence, leadership is an interactive process involving the individual and his or her environment. Learning to be a leader is, in many regards, a developmental process. Beginning very early in life, each of us learns behaviors that influence our environment. That learning occurs both formally and informally through much of our lives. An academic curriculum, for example, is aimed at teaching attitudes, skills, and professional values that will influence our own and others' behaviors.

Identifying and recruiting potential leaders has been the concern of many. Early studies of leadership sought to identify personality traits in order to predict leadership behaviors. These studies, collectively referred to as the "Great Man" theory, produced exhaustive lists of personality variables that were presumed to be more closely correlated with successful leadership than were others. Each new study simply added to the list; no unique pattern of characteristics emerged that could be identified in all situations.

Growing interest in managerial effectiveness caused a shift from trait studies that focused on the leader as an individual to the study of behaviors that constituted leadership. The focus shifted from the role of the leader, a static concept, to the leadership process, a dynamic concept.

Beginning in the late 1940s, a group of studies at Ohio State University (Hemphill, 1950) examined the types of leadership behaviors that are instrumental for the attainment of group or organizational goals. Subsequent work led to the development of behavioral themes that described different leadership styles (Likert, 1961). Two themes, "employee-centered" and "production-centered," emerged. An employee-centered leader was sensitive primarily to the needs and feelings of people, whereas a production-centered leader was inclined to perceive people as tools to get a job done.

Subsequently, studies by Halpin (1966) moved beyond the simplistic notion of "one good style" and found that leadership styles were interactive, that leaders may operate predominantly with one style but are not necessarily limited to that style. Research results, however, supported the notion that leaders who were primarily employee-centered were more effective (Halpin & Binner, 1952; Likert, 1961).

A significant breakthrough in studies of leadership occurred when Fiedler (1967) introduced the continency theory of leadership, which suggests that group performance is a joint function of the leader's motivational structure (style) and the amount of control and influence available to the leader in the situation (environment). Fiedler described leader styles as relationship-oriented, similar to employee-centered, and task-oriented-similar to production-centered. Put more simply, leadership occurs as part of an interaction between the leader's personality/style and the environment in which she or he operates. For example (one often offered by Fiedler), General Patton was a superb tank division commander but would probably not have been a good leader of

a therapy group, and many outstanding therapy leaders would probably make very poor tank division commanders.

Central to the "leadership process" is the concept of interaction between the individual and the environment, and the effect of that interaction on a person's behavior (Lewin, 1938, 1951). The leader's environment can be the climate within a particular organization (Steers, 1979) or it can be a more complex environment external to the organization (Selznick, 1957; Katz and Kahn, 1978). Katz and Kahn (1978) suggest that middle managers need to understand how people above and below them function and to be more aware of the interactions among subsystems, or units, within the organization. Top echelon leaders need to have an open systems perspective and be sensitive to the environmental demands and opportunities created by government agencies and other organizations in the external environment.

Implications for Selecting and Training Leaders in MCH

There are no selection criteria that will assure capability of leadership. However, those who recruit trainees for leadership programs can identify selection criteria that will increase the likelihood of successful academic and professional performance. Powell and Sells discuss these criteria in Chapter Three of this report.

If we accept the premise of leadership as a developmental process, then we can view training as the enhancement of a pathway toward leadership. This training can occur at various points in an individual's professional life. The initial or preservice training generally consists of training in the professional skills of a primary discipline. This discipline may be clinical, as most MCH preservice training is, or administrative, including both administration and management science. Exemplary disciplinary training is a pathway to leadership through professional acclaim. It is through professional excellence that one makes contributions that advance a particular field or discipline. Recognition of this contribution assigns a leadership role to the outstanding professional.

Leadership that is more formal in nature is generally achieved through a career path that leads to administration and management. Most preservice trainees are concentrating on learning their primary discipline. If that is a clinical discipline, trainees are not likely to view themselves on a path that leads to management and administration. Hence their receptiveness to training in management science as a means for developing future leaders may not be high. It is not until they have completed preservice training and begun to perform formal leadership roles as part of their careers that the need for these additional skills becomes apparent. Thus, training leaders in skills that contribute toward effective management and administration is more likely to occur successfully as a form of continuing education.

Private industry has been especially mindful that training not stop at the point of entry into an organization; many organizations invest significant resources into continuing training for management staff.

Current thinking in leadership research suggests that leadership success is contingent upon an individual's ability to interact successfully with her or his environment. Thus, an important part

of leadership development has to do with the development of skills that enhance social influence, such as communication skills, understanding human and group dynamics, negotiation, and other skills related to successful human interaction. Leadership training for executives, a multi-million dollar growth industry in this country, concentrates not on disciplinary skills, but rather addresses personal and professional development. It teaches interpersonal skills relative to creating a favorable climate in which to exercise leadership.

Training potential leaders in MCH should also attend carefully to personal and professional development. This type of training lends itself to both preservice and continuing education. As preservice, professional development is important as a part of any disciplinary training, including both clinical and administrative disciplines. Continuing education or inservice opportunities build upon the professional development that has already occurred.

Subsequent chapters of this report will address the interaction between the trainee/professional and her or his environment. Training approaches that enhance the potential for both formal and informal leadership will also be discussed, as will the need for an environment that supports both personal and professional growth.

CHAPTER TWO:

THE PERSON-ENVIRONMENT FIT CONCEPT APPLIED TO LEADERSHIP TRAINING

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As discussed in the previous chapter, leadership training is a developmental process. Leaders are not born, they develop over time through the process of interaction between the skills and capabilities of the individual and the environmental demands for leadership performance. Leadership depends upon the abilities of a person in relation to the environmental situation; consequently, the person most qualified to lead will vary from one situation to another. Leadership training is a process that probably begins before an individual enters a Division of Maternal and Child Health (MCH) training program and continues throughout that person's professional career. The primary question being addressed in this report is, "How can MCH program faculty facilitate the development of leadership potential within the MCH training program?" In this chapter, a model is presented for guiding discussions on the important components of leadership training. This model is based on a concept of person-environment fit.

Person-Environment Fit

In 1938, Lewin first introduced the theoretical perspective that individual behaviors are determined through an interactional process between a person and his or her environment. Since then, this perspective has been refined and expanded to study organizational behaviors. For example, researchers at the University of Michigan Institute for Social Research (Campbell, 1974; French & Kahn, 1962; French, Rodgers & Cobb, 1974; Harrison, 1980) used the concept of person-environment fit to explain behaviors related to occupational stress. They theorized that stress behavior results from incongruencies between a person and his or her environment. The concept of person-environment fit has also been applied to the study of quality-of-life behaviors for people with developmental disabilities in various life settings (Karan & Berger-Knight, 1986), notably in community-based programs for people who are mentally retarded (Schalock, 1986). In these studies, quality-of-life behaviors are expected outcomes when there is congruence between the needs of the individual and resources within the environment.

Person-Environment Fit and Leadership

It would appear that the concept of person-environment fit can be used as a guide for discussing leadership behaviors and the issues surrounding leadership training. In fact, it can be applied to three separate leadership issues; trainee leadership development, faculty leadership development, and organizational leadership development.

Trainee leadership development. Figure 1 presents a simple model of person-environment fit as it might apply to trainees in any MCH training program. One circle represent the trainee (the person); the other represents the MCH program setting (the environment). The points at which these two circles intersect, and their degree of overlap, indicate the potential for trainee

leadership behaviors. Leadership behaviors will occur if there is congruence between the capabilities of the trainee and the opportunities for leadership training within the MCH training environment. I discuss this model in more detail later in this chapter.

Figure 1.
TRAINEE LEADERSHIP

Figure 2.

FACULTY
LEADERSHIP

Figure 3.
ORGANIZATIONAL
LEADERSHIP

Faculty leadership development. As shown in Figure 2, the person-environment fit concept can also be applied to the ongoing development of leadership among faculty

in MCH programs. This application is based on the assumption that all MCH faculty and staff have certain capabilities and competencies that they can use to lead a group, task force, or agency concerned with improving MCH programs and services, or facilitating positive social change efforts. Evidence of leadership behavior occurs when the competencies of the faculty match the leadership needed within the environment. The environment in which the faculty work is far more complex than that of the student trainee. The faculty environment includes not only the department or agency that houses the MCH program, but also the many institutions, systems, and agencies to which the faculty provide technical assistance, consultation, inservice training, or other community service. As discussed earlier, leadership is a developmental process, and one's potential for leading others in the planning and implementation of social programs and policies should increase over time. Ongoing leadership development among faculty will be influenced by three factors: 1) opportunities to be active in the organizational growth and development of the MCH training program through participation in decision-making or planing groups within the agency; 2) opportunities for continuing education and professional growth through participation in national and state conferences, professional associations, and attendance at regional or state seminars on topics related to particular faculty disciplines; and 3) opportunities to provide technical assistance and consultation to other agencies and to participate on local and regional advisory boards, councils, and task forces.

Organizational leadership development. Figure 3 demonstrates the application of the person-environment fit concept to organizations. In this application, the organization is the entire MCH training program, including faculty, trainees, support staff, and so forth. The environment includes all of the other agencies and organizations that interact with the MCH training program. Leadership in the organization is mobilized when the MCH training program, as an entity, accepts primary responsibility for the development and implementation of plans, programs, or policies that result in positive social change efforts to improve the efficacy of MCH services for children and their families. Organizational leadership should occur when the MCH training program has the resources (knowledge, skills, staff, time and/or money) needed to address the problem(s) identified by several organizations at the national, state, or local levels of service delivery. For example, under PL 99-457 there is a need to develop a comprehensive and cost-effective service program for children from birth through 2 years of age. The design and implementation of this program plan will require effective leadership through an interactional process between the "lead agency" in each state and other state agencies, organizations, and associations. The capability of an MCH training program for providing leadership frequently depends upon: a) the competencies of its faculty and staff; b) the economic and political realities operating within the environment of the organization; c) the ability of the organization's administrators to identify threats to the organization from the external environment; and d) the ability of the administrators to identify opportunities for working collaboratively with other agencies to effect positive social change. However, to some extent, organizational leadership should be an outgrowth of a well-planned and executed MCH training program that promotes the growth and development of leadership potential among its trainees and its faculty.
The remainder of this chapter will focus on issues related to the development of trainee and faculty leadership through an interactional process between the person and the environment.

MCH Leadership Training Programs
The person-environment fit model presented in Figure 1 provides a basic framework for

discussing the leadership training process. Using the concepts described above, one can begin to generate specific goals, objectives, and strategies relative to the trainees, the MCH training program environment, and trainee leadership behavior. Table 1 presents an overview of the primary goals, objectives, and strategies developed by participants at the MCH Leadership Training Conference. The three objectives for trainees, the MCH training program environment, and trainee leadership behavior, respectively, are: a) to identify trainee selection criteria; b) to provide leadership training opportunities, and c) to develop trainee competencies.

Selection criteria. In order to select trainees who have the desire and potential for leadership growth and development, there must be selection criteria to screen applicants for MCH training programs. These criteria can be used later on to develop individualized training programs that build on the capabilities which the trainees acquired prior to entering training.

Table 1. MCH Leadership Training Programs

P - E Fit Component	Goal	Objective	Strategy
Trainee (Person)	Select trainees with the potential for leadership growth and development.	Identify selection criteria.	-interviews -testing procedures
MCH Training Program (Environment)	Develop positive organizational climate that promotes leadership training.	Provide opportunities for leadership training experiences.	-faculty/staff leadership development -organizational planning -organizational networking
Trainee Leadership Behavior	Increase trainee self-awareness, knowledge and skills for leadership potential.	Develop trainee competencies for leadership behavior.	-behavioral objectives related to specific leadership functions -didactic lectures -role models -group process

Leadership training opportunities. The environment of the MCH training program should provide a positive atmosphere, or organizational climate, in which trainees can experiment with leadership roles. The environment in which MCH program faculty work is open to a myriad of influences from the world outside. However, one goal of the leadership training program should be to provide a more closed and protective environment for the trainees. Within such an environment, there should be multiple opportunities for experience-based learning with clearly articulated goals and objectives for the development of trainee leadership potential. Opportunities to participate in a variety of different situations and environments can be created through exposure to the different organizations and agencies where faculty provide technical assistance and consultation, serve on committees, or attend conferences. Each learning opportunity should provide the trainees with additional awareness and knowledge of either their own abilities and growth potential, or of the structure and processes that operate within different situations and settings. As the student acquires knowledge and skills, the opportunities for observation and participation should be expanded to include more complex economic, political, and social situations. Advanced trainees should be encouraged to experiment with their leadership potential through student participation in groups and organizations within the community.

Trainee competencies. The primary goal, of course, is to prepare graduates who have shown evidence of leadership behaviors and who have the potential for ongoing leadership growth and development. In order to accomplish this goal, the main objective is to develop trainee competencies. These competencies should include: a) knowledge and skills related to the trainee's own discipline; b) interdisciplinary knowledge and skills; c) the ability to analyze the leadership needs presented by various economic, political, and social situations within the environment; and d) the ability to exercise leadership in certain situations. Leadership activities by trainees might include facilitating a meeting, program planning, program implementation, and negotiating collaborative working agreements with other groups or organizations. More complex leadership functions, such as representing an agency at public hearings, negotiating budgets and contracts, serving on state and national task forces, directing programs, advocating for needed services, or developing social policies, will be developed and refined throughout the trainee's professional career. However, it is important that trainees have the opportunity to observe more complex leadership roles throughout their training. The competencies of trainees and their leadership behavior will vary considerably.

The success of a leadership training program will depend upon: a) the desire for learning and the capabilities of the student trainee; b) the ability of the MCH training program to provide a positive environment in which faculty can educate and offer opportunities for participating in leadership activities; and c) the ability of the faculty to train students to understand their leadership potential and how to analyze the various situations and environments in which they may be working.

Chapter Four addresses the importance of the organizational climate for enhancing leadership potential among both trainees and faculty. Other chapters focus on trainee selection criteria, trainee leadership behavior and competencies, and issues related to the evaluation of leadership training programs.

CHAPTER THREE:

SELECTING TRAINEES AS FUTURE LEADERS

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Although one may stimulate considerable debate when discussing what leadership is, and how we evaluate it, there is little discussion as to the importance of the proper selection of individuals if they are eventually to become leaders. Without certain innate characteristics, an individual is less likely to eventually be recognized as a leader than the individual who possesses these attributes. Others would argue that the environment one is exposed to during the formative period plays at least as important a role as innate abilities in determining leadership. Polarization in either direction ignores the concept of leadership as a result of certain innate characteristics of an individual that are modified, developed, and refined as a result of exposure to one's environment.

Leadership Indicators

What then are the characteristics thought important in the selection of trainees destined to become leaders? The following are some indicators of candidates who have potential for leadership:

1. The trainee's career goals are compatible with the content of the program.
2. The trainee has good verbal and written communication skills.
3. The trainee is self-motivated.
4. The trainee has already acquired basic clinical skills for his or her particular discipline prior to acceptance into the program.
5. The trainee is flexible and adaptable.
6. There is a demonstrated interest in teaching.
7. The trainee has evidence of significant personal achievement.
8. There is evidence of academic achievement.
9. There is a demonstrated interest in research.
10. The trainee possesses excellent interpersonal skills.
11. The trainee demonstrates maturity manifested in previous experiences.

This list is not all-inclusive, nor do future leaders necessarily need to possess all of these characteristics. Trainees with these basic attributes, however, are more likely to become leaders in the field.

Information necessary to determine if an applicant possesses the desired characteristics listed above can be derived in the following ways:

		Leadership Indicator*
☞	A letter from the applicant stating why he/she is seeking this training and an overview of his/her goals.	1, 2, 3, 6, 9
☞	A completed application or a curriculum vita.	4, 6, 7, 8, 9, 11
☞	Official academic transcript(s)	4, 8
☞	Verified letters of reference from persons who can attest to personal and professional knowledge of the candidate, such as a major professor, departmental chairman, or a current employer.	4, 5, 7, 8, 9, 10, 11
☞	Personal interview of applicant with appropriate representatives of the training program.	1, 2, 3, 5, 10, 11
☞	A writing sample, such as a major paper or publication.	2, 9
*	Refer to selected indicators listed above.	

Evaluation

Trainee selection committees will need to develop evaluation tools to assist them in ranking data collected on applicants. This tool will then bring the selection process to a more objective level. Committees can use a Likert-type scale, such as the following, to identify areas of strength and weakness in applicants.

		Evidence		
Leadership Indicators		**None**		**Strong**
1.	Career goals are compatible with MCH	1	2	3
2.	Good verbal communication skills	1	2	3
3.	Good written communication skills	1	2	3
4.	Self-motivation	1	2	3
5.	Basic clinical skills already acquired	1	2	3
6.	Flexibility and adaptability	1	2	3
7.	Interest in teaching	1	2	3
8.	Significant personal achievement	1	2	3
9.	Academic achievement	1	2	3
10.	Interest in research	1	2	3
11.	Excellent interpersonal skills	1	2	3
12.	Maturity	1	2	3

MCH training programs are diverse and target training to persons with a broad range of academic credentials and professional experience. Each program will necessarily design the selection criteria to best match its own mission for preparing trainees.

Master's degree programs will establish criteria for evidence of leadership potential that will differ from programs that focus on post-doctoral training. The leadership indicator would remain the same, the evidence of the indicator would differ.

CHAPTER FOUR:

THE LEADERSHIP ENVIRONMENT

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Training leaders is a complex process. From this process emerge those skills that enhance an individual's opportunity to assume leadership roles professionally and personally. Such skills may be acquired in clinical or management disciplines, or through personal/professional development. Training can be offered in a variety of formats that include didactic presentations and "hands-on" experiences.

Training is a dynamic process that is influenced by the design and structure of the training opportunities as well as the environment in which they occur. In addition to capable trainers, what do you need to accomplish good training? You need a supportive organizational environment.

Organizational researchers have become increasingly aware of the reciprocal relationship between people and their organizational environment. One role of an organization such as a university is to provide a caring environment for people who are part-time or full-time organizational inhabitants. The ability of an employee (in this case, a trainer) to effectively contribute to the overall success of the organization (producing successful graduates) is affected by the working environment in which organizational activities (training) occurs.

The organizational environment or climate in which training occurs represents the culture of the organization. It is composed of shared values and beliefs. As with all cultures, the training culture is a dynamic evolving construct. It is composed of thoughts and behaviors shared by a group. As elements change-such as group membership, organizational structure, knowledge available to the group, or belief structures-the culture changes as well.

Organizational culture can affect training in several ways. First, faculty and staff within the organization who are responsible for the training are likely to perform most effectively in an environment that is nurturing and rewarding. Second, the values and beliefs of an organization are communicated to trainees through the attitudes and behaviors of the faculty and staff. A program whose goal is to train skilled practitioners and future leaders must create a climate in which excellence is recognized, practiced, and rewarded.

Dr. Leland Kaiser, nationally known for his expertise in the psychology of health care organizations, offers the following characteristics of a nourishing organizational climate:

1. It is financially stable.
2. It is well managed.
3. It encourages risk taking.

4. It gives faculty/staff time to think.
5. It provides essential library and computer resources.
6. It coaches people on techniques related to accomplishing their role in the organization.
7. It celebrates success.
8. It rewards innovation.

(Kaiser, 1987)

The findings from current organizational research suggest that the success of an organization is significantly affected by the degree to which the employee shares organizational values and goals, feels personally valued, has a sense of responsibility and influence, and finds opportunities for professional growth and development. These factors motivate people more often than financial incentives.

Accomplishing organizational goals requires energy. If an organization is in administrative chaos or the throes of financial disaster, or has deteriorated into defensive game playing, valuable energy is consumed by employees whose main concern is self-protection (Kaiser, 1987).

Interdisciplinary training, as practiced in MCH-sponsored training programs, is a good example of the combination of structured training experiences and the creation of an organizational climate that is important to the learning process. Participating on an interdisciplinary team gives a trainee an opportunity to practice her or his own disciplinary skills and learn what other disciplines have to offer in solving the complex problems of children with handicaps and their families. This opportunity generally occurs through a planned and supervised learning experience.

Equally important is the opportunity to participate in an interdisciplinary environment. Trainees learn the underlying beliefs and values upon which the interdisciplinary process is based. Further, they learn important group activities including how to present their information and listen carefully to others. Trainees are likely to experience the conflicts that come about as a result of basic differences of opinion, strong intra-professional loyalty, professional territoriality, and other human dynamics that affect group decision-making. They participate in and observe negotiations regarding team recommendations that are intended to ultimately benefit the child and family. They have an opportunity to model their professional behavior after the behavior of training supervisors and other professionals participating on the team.

The social environment that is created by the team is influenced by all participants, especially when change in participation occurs. It is affected by the motivation and attitude of participants which, in turn, are shaped by the environment. In general, a healthy environment contributes to a positive outcome or experience.
The climate of the total organization in which training occurs is as important as the team environment used in this example. MCH-sponsored training programs can and do enrich their organizational environments in many ways, including those identified by Dr. Kaiser. More specifically:

a. Programs exist in university environments that are rich in research, library, computer, and other resources. There must be access to these resources and time available to benefit from them.

b. Programs have experts in many fields available to them throughout the university. These fields may include clinical areas of interest or specific skill building activities having to do with personal/professional development. These resources need to be identified and made available to program faculty, staff, and trainees for professional growth opportunities, which might include additions to existing curricula, workshops offered periodically, inservice training, and leave time for staff to participate in activities at another site on campus. Participation in regional and national conferences also serves this purpose.

c. There are many ways to recognize and reward excellence. They range from a simple "Thank you, good job" to organized celebrations. They can include enhanced compensation. What works best differs from one organization to another. The important thing is that they occur.

d. MCH-sponsored training programs are complex. They have multiple purposes and a complex organizational structure. Lines of authority are not always clear, nor are roles and responsibilities. Communication is an important ingredient in the successful management of these programs. That communication must go from the bottom to the top of the organization as well as laterally. Vertical communication is generally routed according to lines of authority expressed on an organizational chart. Lateral communication occurs through mechanisms such as committees, task forces, staff meetings, and special seminars. A nourishing environment will attend to communication in all directions.

e. The nature of public funding, which supports MCH-sponsored training programs, makes financial stability a relative term. However, the greatest organizational anxiety often arises from lack of information about what the financial status is, rather than from knowing it is, perhaps, difficult at a particular point in time. Hence, effective management practices would include keeping people informed about the organization's financial status, positive or negative, and allowing for broad input into decision-making.

Attending to the training environment will improve the effectiveness of the training faculty and staff. Further, it will create an opportunity for trainees to observe and participate in a rewarding group experience. Trainees will have an opportunity to be part of the organizational life, participating on teams and committees, and receiving recognition. As appropriate, trainees can assume responsibility and leadership roles. They can observe others providing effective leadership. The values associated with the MCH training mission will be more clearly communicated.

CHAPTER FIVE:

TRAINEE BEHAVIORS

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The term "competency area" was adopted by the conference participants to depict those behaviors/competencies that could be addressed in a curriculum to facilitate the development of leadership skills. Each of the four working groups at the conference reached consensus on the following unranked list of competency areas: character strength, communication, interpersonal skills, management, networking, strategic planning, teaching, and research.

For each area there are descriptors or clusters of behaviors that represent a best match by participants.

Competency Area	**Descriptors**
Character Strength	- taking risks - knowledge of individual strengths - commitment to the field - ability to take criticism - sense of human - self-acceptance - knowing limits of own knowledge - initiative - flexibility, adaptability, improvisation
Communication	- listening skills - verbal and written skills - public speaking - giving and receiving information

Competency Area	**Descriptors**
Interpersonal Skills	- group process - conflict resolution - negotiation - relationship development interdisciplinary cultures, religion, ethnic groups, etc. - personal style task oriented relationship oriented
Management	- budgeting - personnel - proposal writing - marketing - technology use
Networking	- building connections - identifying key people and resources - understanding other systems - outreach to populations - professional affiliations
Strategic Planning	- problem identification - conceptual thinking - analytical thinking - program development - identifying policy changes - identifying population change patterns - formulating a vision mission, goals, objectives
Teaching	
Research	- basic and applied - conducting survey - data management - evaluation program effectiveness content - critical reading - basic statistics

The identification of competency areas and behavior clusters is a promising first step in defining the parameters of a curriculum. These competency areas represent the content of training, but the level of acquisition (i.e., awareness, knowledge, or skill) will require further specification.

Instructional Activities

Conference participants outlined a variety of strategies to address the delivery of inservice training. These strategies are based on the premise that leadership training must be ongoing and integrated throughout the training experience in order to influence the development of leadership skills in our trainees. The strategies include teaching methods currently used in a variety of MCH training programs. For each strategy, specific examples show how to incorporate the teaching of these competency areas into our training programs.

Strategies	**Examples**
First-hand involvement	- facilitate a group meeting - attend advocacy meetings - involvement in legislative process participate in hearings meet with government officials
Core Lecture Series	- Title V, legislative process, funding mechanisms, community service resources - career planning
Case Based	- interagency collaboration - parent groups - interdisciplinary function - self-awareness, development, role identification
Provide Role Models	
Networking	- providing contracts with key people - introduction to "movers and shakers"
Research Participation	- proposal writing - critical reading - applying findings
Applied Management/Problem Solving	
Teaching/Conference Presentations	

Evaluation

An evaluation of existing training programs in terms of the competency areas and instructional activities noted above is necessary, because the results of evaluation will lead to recommendations for amending or expanding training curricula. Surveys of instructors and trainees might be sources of additional information.

Furthermore, in order to adequately evaluate training programs, trainers must develop clear instructional objectives. For each competency area, they must write instructional objectives that describe the intended educational outcomes using the appropriate teaching strategies. There are three steps in writing instructional objectives: 1) identify and name the overall behavior act that is accepted as evidence that the learner has achieved the objective; 2) define the important conditions under which the behavior is to occur; and 3) define the criterion of acceptable performance. The formulation of instructional objectives will allow for the specification of level of acquisition and additionally provide a strategy for summative evaluation.

CHAPTER SIX:

THE IMPACT OF MCH LEADERSHIP TRAINING PROGRAMS

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This chapter focuses upon the long-term outcomes of MCH training programs and their influence and impact on the entire field of maternal and child health. The preceding chapters in this report have discussed leadership training in MCH programs in terms of the selection of trainees and the characteristics, experiences, and skills that the trainee brings to the training situation; the characteristics of the MCH training program in terms of organizational climate; the competencies or behavioral outcomes gained by the trainee as a result of participating in the training program; and the interaction among these components. In reference to MCH training programs, what do we mean by impact, how is it achieved, and how do we evaluate it?

What is Impact?

The overall mission of the Division of Maternal and Child Health remains constant: to improve the health of mothers and children, especially those living in poverty and with special health care needs. A fundamental MCH goal is that of training leadership personnel who will play a key role in implementing the overall MCH mission. The training of leadership personnel is consistent with one of the original concepts of the University Affiliated Facilities (UAFs), one type of MCH training program. The intent behind the establishment of the UAFs was and remains to prepare "seed personnel" to act as key agents for improving the delivery of complex health and social services to the maternal and child health population. Trainees learn state-of-the-art models of service delivery during the training program and implement these models in career settings from academic institutions to centers of direct care delivery. This "seed personnel" concept evolved as a major strategy to bring about improvements in the care of mothers and children served by MCH programs. Have MCH training programs and their graduates contributed to improvements in care and services? What are the long-term effects of these programs in regard to the overall goals and mission of MCH?

How is Impact Achieved?

Leadership is an important component of any significant changes in care and services. Leadership is a process in which a person influences others to attain a common goal (Stogdill, 1974). MCH training programs attempt to enhance the effectiveness of the leadership process demonstrated by graduates through establishing criteria for the selection of trainees, establishing an organizational climate within the training program conducive to the leadership process, and

designing the training program around specific competency areas. These three sets of variables interact to enhance the ability of the graduates to become leaders in maternal and child health. The outcome of this process is improvement in care and services.

As leaders, the graduates of these training programs contribute to the MCH mission by: a) disseminating existing knowledge; b) applying existing knowledge in effective and innovative ways; c) expanding the base of knowledge through research; d) bringing new developments in a particular discipline to bear on issues of maternal and child health; e) establishing/improving services; f) attracting new qualified trainees to the field; and g) developing effective national and state policies for mothers and children.

The specific contributions will differ according to many variables, including level and type of training received and career option selected. Career settings may include human service agencies and organizations, colleges and universities, federal, state, or local government agencies, and advocacy organizations. These settings have different goals and activities and provide different opportunities for professionals.

How is Impact Evaluated?

Impact evaluation is a challenging task, with many approaches. How do we know if MCH training programs are effective and contributing to the mission of MCH? At a broad level, we can review the health status changes of mothers and children using indicators such as infant mortality or time of onset of prenatal care, or we can examine changes in care and services. The difficulty is proving that MCH training contributes to either improved services or health status. Social change is the result of many variables; it is extremely difficult, if not impossible, to relate one variable-MCH training programs-to social change in general.

Another approach is to evaluate the impact in terms of the basic goal of the MCH training program -- to train leadership personnel. Do MCH training programs produce graduates who have a positive impact on the health status of mothers and children and the system of services according to the mission of MCH? The contributions of MCH training program graduates then become the focus of analysis.

Now the question becomes: Are MCH graduates contributing to improvements in services? But how can we measure these contributions? It is difficult to directly assess the effects of MCH graduates on improvements in services, but we can use both quantitative indicators of impact and qualitative or descriptive data to address these questions. A combination of several traditional indicators of career development may be relevant:

- publications (or citation index)
- professional and community presentations
- funded grants
- teaching activities
- board, committee, task force involvement

- professional organization involvement
- participation on grant review panels, site visit teams, etc.
- legislative testimony
- awards/honors

None of these indicators alone demonstrates a capacity for leadership, but a combination of them can be viewed as a reflection of one's ability to influence others and contribute to improved services.

In addition, periodic contacts with former trainees and their employers may provide information about any positive contributions by trainees to improved MCH services. For example, a trainee may have played a role in creating new legislation and regulations, or in developing new applications of knowledge or innovative models of service delivery, etc. These descriptive data may be a useful form of feedback to the training program.

This approach to assessing the impact of MCH training programs can lead to a further review of specific issues, to modifications in programs, and to the identification of areas for continuing education. In addition, the types of indicators listed above are sensitive to the career development of professionals and can be analyzed on an individual basis.

The approach described here provides a framework to address the long-term outcomes of MCH training programs. While it may provide very useful information, no easy method exists to directly relate a person's contributions to her or his participation in the MCH training program. Such a conclusion appears extremely difficult to reach and would require complex experimental designs and extensive resources. Even a comparison of MCH program graduates with graduates not trained in MCH programs would be a difficult task. Limited resources may be better spent on developing an ongoing, systematic approach to the contributions of MCH program graduates.

A careful analysis of the long-term outcomes of MCH training programs and their graduates remains essential to document the extent to which these programs are meeting the MCH training goal. Some programs are looking more carefully at the activities of their graduates. These efforts should continue and expand with increased attention to relevant indicators that reflect the goal of the training program -- the training of leadership personnel.

CHAPTER SEVEN:

SUMMARY AND CONCLUSIONS

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The MCH Leadership Training Conference held in September, 1987 was extremely difficult but fruitful. The primary problem experienced by conference participants was that of understanding and assimilating new concepts related to leadership training. Traditionally, MCH training programs have been educating students to be "leaders" in the field of maternal and child health. The first presentation, however, challenged the concept of "leaders" as people with certain abilities, traits, or personal characteristics. Instead, leadership was defined as a interactional and developmental process. Leadership occurs when the abilities of a person match the leadership needs in a particular situation.

This concept of leadership, as interactional and developmental, has several implications for MCH training programs. First, there is a need to teach students how to: a) recognize their inherent capabilities, b) expand upon those capabilities, c) acquire new disciplinary and interdisciplinary knowledge and skills, d) learn how to assess a situation, and e) decide whether they have the capability to provide leadership at any particular moment in time. Second, in addition to training students, MCH training programs need to be concerned with the ongoing growth and development of their faculty and staff for leadership potential. Third, there must be new methods of evaluating the success of MCH training programs for developing leadership potential. Previous evaluation measures have focused on the number of people who have attained positions in the upper hierarchy of MCH programs and agencies. The definition of leadership presented at the conference implies that graduate trainees may in fact be providing leadership in a variety of settings and situations, regardless of their placement in the social service structure. Therefore, it is important to develop outcome measures that evaluate: a) the effectiveness of training strategies for accomplishing specific objectives, b) the effectiveness of the objectives for reaching the program goals, and c) the summative effect of the MCH training programs.

Conference participants, as a result of their efforts, initiated the following five action plans:

1) They decided that this document, which serves as a report on the conference, be written to include specific chapters on the critical issues in the development of trainee leadership potential and MCH training programs.

2) A task force was appointed to explore the feasibility of establishing competency

requirements for trainees based on the interactional and developmental definition of leadership. Most likely, task force members will have to come up with multiple competency requirements which can be used to develop individualized training programs that build on the existing capabilities of trainees.

3) Another task force was appointed to develop indicators of the impact of leadership training on programs and policies aimed at improving the delivery of services to mothers and children. The purpose of this task force is two-fold. First, it will examine methods for evaluating the effectiveness of various training methods and outcomes within a leadership training program. Second, it will explore the feasibility of developing outcome measures to evaluate the impact of MCH training programs on social programs and policies.

4) A small group of individuals accepted responsibility for writing a questionnaire to obtain information from the MCH training programs represented at the conference. They obtained information regarding trainee selection criteria, opportunities for leadership growth and development by trainees and faculty, and the competency requirements for leadership behavior among trainees.

5) A committee was appointed to begin planning for a second conference to be held in the spring of 1988. The reports of the two task forces and the results of the questionnaire will be shared with conference participants prior to the beginning of the meeting. The purpose of the spring conference is to further expand and refine the work done to date, and to prepare specific guidelines for improving leadership training programs.

The direction provided by participants at the first MCH Leadership Training Conference was insightful and innovative. As the realities of providing services to mothers and children increase in complexity, it becomes more and more obvious that MCH trainees are needed to meet the demands for leadership at the local, state, and national levels of service delivery. If, however, we insist that leadership is a position rather than a function, we create unrealistic and unfair demands upon our faculty and our trainees. More importantly, we do little to improve social conditions for mothers and children.

Participants at this conference accepted the new definition of leadership as a process. However, they struggled with ways to use that definition to develop behavioral objectives and valid evaluation measures that might be applicable for all MCH training programs. The task is not an easy one, but we are off to a good start.

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LEADERSHIP TRAINING II

Conference Report

The report of a second conference on leadership training in Maternal and Child Health-funded training programs.

April 23-25, 1988

Supported through the Division of Maternal and Child Health Grant No. MCJ 000916 at the University of North Carolina, Chapel Hill.

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PREFACE

From September 19 through September 21, 1987, and again from April 23 through April 25, 1988, representatives of the Maternal and Child Health funded training programs family met to develop a guide to be used for leadership training. "Family members" from MCH funded interdisciplinary training programs - adolescent health projects, behavioral pediatrics projects, MCH training in schools of public health, pediatric pulmonary centers, University Affiliated Programs - and state MCH-Crippled Children's programs were present.

One of the recommendations of the first conference was the need for a second conference. The recommendations also included the forming of two task forces: one to explore the feasibility of establishing competency requirements for trainees based on the interaction and developmental definition of leadership, the other to develop indicators of the impact of leadership training on programs and policies aimed at improving the delivery of services to mothers and children. A questionnaire was developed to obtain information from the MCH funded training programs regarding trainee selection criteria, opportunities for leadership growth and development by trainees and faculty, and the competency requirements for leadership behavior among trainees. These data were the basis for discussion that led to the development of this report. The report of the first conference provides the proper perspective for the developmental sequence of the conferences. The report of the second conference is in loose leaf form for programs to modify and utilize as a training manual.

The conferees were able to arrive at consensus without difficulty, a clear demonstration of the adaptability and commitment of the various MCH funded training programs. That there are "real" differences among these programs is obvious but, as one participant observed, that the conferees were able to "overcome" these is a practical demonstration of interdisciplinary interaction.

Over the years, the "MCH difference" in its training programs has been a much discussed quality. Another of the participants wondered if the success of these two conference was due to this difference. It may well be that this quality is what enabled the conferees to arrive at the present document.

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BASIC TENETS OF LEADERSHIP TRAINING

The following concepts summarize the theoretical background material presented during the conference and available in more detail from the project coordinators in the Leadership Training I Conference Report, September 19-21, 1987.

- Leadership is an ongoing, dynamic process, not a goal or a definable position one can achieve.

- No unique pattern of personality characteristics has ever been identified which can be closely correlated with successful leadership; the "Great Man" theory of early leadership studies could not be proven.

- Leaders are not born, they develop over time through the process of interaction between the skills of the individual and the environmental demands for leadership performance.

- Leadership occurs when the abilities of a person match the leadership needs in a particular situation. People may be effective leaders at different times in different environments; the person most qualified to lead will vary from one situation to another.

- An important part of leadership development is to offer an array of opportunities for the trainee to interact with various economic, political, and social environments.

- While it is not possible to train someone to be a "leader" per se, it is possible to focus on certain leadership competency areas for the purpose of developing awareness, knowledge, and skills to influence the environment positively.

- Leadership training should not be a separate course or curriculum but an approach which is integrated into all training activities and situations that promote an awareness of the "larger picture" and the development of interactive skills needed to make an impact.

TRAINEE SELECTION CRITERIA

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Although one may stimulate considerable debate when discussing what leadership is, and how we evaluate it, there is little discussion as to the importance of the proper selection of individuals if they are eventually to become leaders. Without certain innate characteristics, an individual is less likely to eventually be recognized as a leader than the individual who possesses these attributes. Others would argue that the environment one is exposed to during the formative period plays at least as important a role as innate abilities in determining leadership. Polarization in either direction ignores the concept of leadership as a result of certain innate characteristics of an individual that are modified, developed, and refined as a result of exposure to one's environment.

Leadership Indicators

What then are the characteristics thought important in the selection of trainees destined to become leaders? The following are some indicators of candidates who have potential for leadership:

1. The trainee's career goals are compatible with the content of the program.
2. The trainee has good verbal and written communication skills.
3. The trainee is self-motivated.
4. The trainee has already acquired basic clinical skills for his or her particular discipline prior to acceptance into the program.
5. The trainee is flexible and adaptable.
6. The trainee has evidence of significant personal achievement.
7. There is evidence of academic achievement.
8. There is a demonstrated interest in research.
9. The trainee possesses excellent interpersonal skills.
10. The trainee demonstrates maturity manifested in previous experiences.

This list is not all-inclusive, nor do future leaders necessarily need to possess all of these characteristics. Trainees with these basic attributes, however, are more likely to become leaders in the field.

Information necessary to determine if an applicant possesses the desired characteristics listed above can be derived in the following ways:

	Leadership Indicator*
A letter from the applicant stating why he/she is seeking this training and an overview of his/her goals.	1,2,3,8,
A completed application or a curriculum vita.	4,6,7,8,10
Official academic transcript(s).	4,7
Verified letters of reference from persons who can attest to personal and professional knowledge of the candidate, such as a major professor, departmental chairman, or a current employer.	4,5,6,7,8,9,10
Personal interview of applicant with appropriate representative of the training program	1,2,3,5,9,10
A writing sample, such as a major paper or publication	2,9

*Refer to selected indicators listed on the previous page.

Evaluation

Trainee selection committees will need to develop evaluation tools to assist them in ranking data

collected on applicants. This tool will then bring the selection process to a more objective level. Committees can use a Likert-type scale, such as the following, to identify areas of strength and weakness in applicants.

	Leadership Indicators		**Evidence** None	Strong
1.	Career goals are compatible with MCH	1	2	3
2.	Good verbal communication skills	1	2	3
3.	Good written communication skills	1	2	3
4.	Self-motivation	1	2	3
5.	Basic clinical skills already acquired	1	2	3
6.	Flexibility and adaptability	1	2	3
7.	Significant personal achievement	1	2	3
8.	Academic achievement	1	2	3
9.	Interest in research	1	2	3
10.	Excellent interpersonal skills	1	2	3
11.	Maturity	1	2	3

MCH training programs are diverse and target training to persons with a broad range of academic credentials and professional experience. Each program will necessarily design the selection criteria to best match its own mission for preparing trainees.

Master's degree programs will establish criteria for evidence of leadership potential that will differ from programs that focus on post-doctoral training. The leadership indicator would remain the same, the evidence of the indicator would differ.

OBJECTIVES

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MCH-sponsored training programs acknowledge a major responsibility for training leaders in areas which affect the delivery of services to children and their families. In general, trainees are well prepared to meet the performance expectations for their clinical disciplines, and to work effectively with people from a broad range of other disciplines. These same trainees, however, may lack the requisite administrative or management skills as they move to positions of leadership and influence within an organization.

In identifying the personality characteristics and skills involved in successful leadership behaviors, an extensive list of descriptors can be amassed which ultimately becomes overwhelming. The list becomes overwhelming because it implies that MCH training programs have the responsibility and ability to: 1) mold or change a trainee's basic personality, 2) develop basic communication and interpersonal skills, 3) develop basic disciplinary knowledge and clinical skills, 4) develop knowledge and skills within the focus area of the particular MCH training program, and 5) develop the knowledge and skills for leadership behaviors. And, this is to be accomplished, in the UAPs, for example, in what may be only a 9-12 month, 16-20 hour per week training program!

To make leadership training seem a less formidable endeavor, the identification of areas which should be included within the training program may need to be based on certain premises:

> Trainees entering the program are selected based upon criteria which include: 1) good basic knowledge and clinical skills in their particular disciplines, 2) good verbal and written skills, and 3) excellent interpersonal skills. Opportunities to further develop these areas should be part of the training activities but they should not be basic components of the curriculum.
>
> The area of character strength involves descriptors which include personality characteristics (e.g., sense of humor, flexibility, self-acceptance, etc.) which are part of the trainee when she/he enters the program. These characteristics are important, and opportunities for growth should be part of the training activities but they should not be basic components of the curriculum.
>
> Many MCH training programs have curricula in place to provide their trainees with the professional knowledge and skills needed for client/patient-centered activities within their particular area of focus (e.g., adolescent health, developmental disabilities, etc.). Leadership training activities should focus on increasing the professional knowledge and skills needed for environment-centered activities.
>
> The level of acquisition (awareness, knowledge or skill) within content areas and the specific behavioral competencies of trainees will be dependent upon the specific training activities used by the individual MCH training program, as well as upon the individual

trainee.

MCH training programs may need to place increased emphasis upon areas in order to ensure the trainees are prepared to meet the performance expectations of leadership positions. Areas to be included are Administration/Management, Strategic Planning, Public Policy/Interagency Collaboration, and Teaching/Research.

The following are sample objectives and activities that could be used to complement current training initiatives. Each program will have to develop its own goals relative to the competencies set forth in Chapter 5 of the Leadership Training I Conference Report that are suited to its program and trainees.

ADMINISTRATION/MANAGEMENT**

GOAL: The trainee will understand the interdependent nature of clinical and administrative perspectives so that they might alter the practice of their own discipline accordingly.

Objective 1: To demonstrate an understanding of both clinical and administrative perspectives as they affect direct care. (Attachment A)

Objective 2: To name at least five content areas in Administration and explain how the major concepts/approaches/tools affect direct care. (Attachment B) The major content areas include:

- Organization Theory and Design
- Planning, Marketing, and Control
- Financial Management
- Human Resources Management
- Management Information Systems
- Legal Issues and Advocacy
- Health Economics
- Health Care Systems
- Facilities Management
- Quantitative Methods and Research

Activities:

- Develop an action plan to solve an administrative problem
  - -- Referral sources not receiving reports on a timely basis
  - -- Callers placed on hold for long periods
  - -- Support staff have been rude and short tempered

- Develop a division budget
- Develop a proposal budget and justification
- Prioritize requests for equipment
- Attend agency personnel allocation meetings
- Review operating policies and procedures

** Materials in this section were drawn from Introduction to Administration: Training Coordinator's Guide University-Affiliated Programs. Elynor Kazuk 1987, with permission from Dome Learning Systems, Baltimore, MD.

Attachment A

CLINICAL AND ADMINISTRATIVE PERSPECTIVES

An understanding of Administration begins with an awareness of how an administrative perspective regarding any incident, case, or clinical program differs from a clinical perspective. In general, this difference can be summarized as follows:

	Clinical		Administrative
1.	Single case oriented.	1.	Population and organization oriented.
2.	Focused on direct care of patient/client/family.	2.	Focused on issues in environments surrounding case.
3.	Expertise in technical fields affecting the case.	3.	Expertise in general processes and management.
4.	Recommends optimal quality care per case.	4.	Recommends optimal care within limited resources.
5.	One-on-one communication emphasized.	5.	Whole group communication emphasized.
6.	Work is done by self.	6.	Work is delegated to others.

These two approaches, together, create a total system of care for the patient.

Attachment B

ADMINISTRATIVE SUB-SPECIALTY AREAS

Administration, in this program, is defined as an academic discipline which encompasses the theoretical areas* listed below:

Organization Theory and Design - includes establishing mission, major policies, rules, relationships, coordinating work flow, and communication.

Planning, Marketing and Control - includes strategic and long-range planning, determining consumer needs, establishing goals and objectives, assuring progress and quality.

Finical Management - Includes financial planning, budgeting, reimbursement for service, grants management, cost containment, capital formation, and materials management.

Human Resources Management - includes behavioral sciences, policy-setting, manpower planning, recruiting, personnel administration, and management skills.

Legal Issues and Advocacy - includes health law and legislation, risk-management, confidentiality, informed consent, assuring guardianship, and compliance with established legislation.

Management Information Systems - includes computer literacy and data systems, understanding technological options, optimizing information gathering, and effective reporting.

Health Economics - includes economic appraisal and evaluation of different courses of action, cost-benefit analysis, probability concepts, and supply and demand studies.

Health Care Systems - includes general elements of health system in the U.S. and state, organization of medical care, health facility functions, and alternative delivery systems available in the community.

Facilities Management - includes space planning and allocation, energy systems, building design and construction, safety and infection control, and internal building environment.

Quantitative Methods and Research - includes statistical methods, health care research, forecasting techniques, decision science, operations research, and mathematical models.

* Parallels those areas outlined by the Accrediting Commission on Education for Health Services Administration as well as the American Association of University Health administration Programs.

STRATEGIC PLANNING

GOAL: The trainee will acquire an awareness of strategic planning through an understanding of its basic components which include:

Objective 1: To describe the differences between strategic and operational planning.

Objective 2: To demonstrate awareness of the importance of population based health care planning, i.e., formulating the vision: long range planning.

Objective 3: To identify the components of strategic planning.

Activities:

- Critical reading
- Observe small interagency work group and review with mentor
- Develop agenda for interagency work group
- Prepare strategies/format for interagency work group
- Identify structure and purpose of work group
- Participate in preparation of grant proposal
- Conduct a program analysis

PUBLIC POLICY/INTERAGENCY COLLABORATION

GOAL: The trainee will have a knowledge of the role of public policy/interagency collaboration and its impact on the service delivery system as it relates to the status of mothers and children.

Objective 1: The trainee will describe the rationale for interagency collaboration which includes problems associated with multiple providers, inefficiency or fragmentation of services, limits/gaps in services, and duplication of services as well as opportunities for professional development and facilitation of strategic planning.

Objective 2: The trainee will be aware of the importance of historical perspective in terms of the political and philosophical orientation of MCH and related agencies serving mothers and children.

Objective 3: The trainee will describe the legislative process related to the development of public policy.

Objective 4: The trainee will list strategies for influencing the legislative process related to the development of public policy.

Objective 5: The trainee will relate the function of the legislature to the development, administration, and funding of public policy.

Objective 6: The trainee will identify mechanisms for achieving interagency collaborations.

Activities:

- Be introduced to key persons/agencies
- Attend interagency committee meetings
- Attend professional meetings
- Interview key state and federal personnel
- Attend legislative meetings/hearings

TEACHING AND RESEARCH

GOAL: The trainee will demonstrate an understanding of teaching and research strategies as they relate to improving the delivery of services for mothers and children.

Objective 1: To demonstrate teaching ability, including:

- Understanding of subject material
- Organization of material for presentation at a level appropriate to the audience
- Public speaking ability
- Effective use of audiovisual teaching aids
- Understanding techniques of evaluation

Objective 2: To understand clinical research methods and skills including:

- Scientific method
- Analytical methods including basic statistics
- Scientific writing
- Data Analysis
- Critical reading
- Study design

Activities:

- Classroom teaching
- Community workshop presentation
- Conference presentation
- Foster session development and presentation
- Grand rounds case presentation
- Questionnaire development
- Conduct survey
- Collect/analyze data
- Critical literature review
- Summarize program ealuation data
- Design a study
- Participate in research project

EVALUATION

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The importance of an evaluation component to the leadership training process is a given. Evaluation strategies should allow program administrators to determine whether the MCH training program produces graduates who have a positive impact on the health status of mothers and children and on the system of services. A valuable approach in answering this question is self assessment. The above-mentioned follow-up survey should include items assessing the graduates' perception of contributions to both clients and the health care system. Comparative data sought from employers would enhance administrators' understanding of training program strengths and weaknesses. To this end, the evaluation task force of the leadership conference committee is designing and field-testing a survey for use by both MCH training program graduates and their employers. Data from such a survey will be the first step in addressing the issue of impact evaluation.

Two versions of the questionnaire developed by the indicatiors impact task force are presented. The first one represents the minimum amount of information recommended for programs to collect on their former long-term trainees. The second (three page) questionnaire is an expansion of the first one and would enable programs to collect specific information in greater detail.

The basic questionnaire was developed based on areas which were discussed at the conference as possible indicators of leadership. The first part is designed to collect primarily demographic information, some of which may already be on file, or may only need to be collected once (e.g., ethnic identity). The second part is designed to collect data which are referred to as indicators.

Date:

Name:
Current Address and Telephone Number
Work:
City:_____State:_____Zip:
Phone:( )

Home:
City:_____State:_____Zip:
Phone:( )
Permanent contact (someone who will know your address):
Name:
Address:
City:_____State:_____Zip:
Phone:( )
Racial Identity:
_____White _____American Indian/Alaska Native
_____Black _____Asian/Pacific Islander
Ethnic Identity: _____Hispanic_____Non-Hispanic
Sex: _____Male _____Female
Highest Degree Held:_____ Discipline of Higher Degree:

While you were in our training program:
Discipline in which you were trained:
Level of degree program in which enrolled or level of post-degree training:
Year you completed our program:

Present Employer:
Position Title:
Type of employment:
_____Direct Service _____Governmental (Local, State, Federal)
_____Private Practice _____Business/Consultative
_____Teaching Institution _____Other (specify)
Are you currently involved in activities (e.g., service, training, research, advocacy, community, etc.) which impact on the health of mothers and/or children? _____Yes _____No

If YES, please answer the following questions in terms of <u>your involvement as related to the area of maternal and/or child health</u>:

Do you spend more then 50% of your time in non-direct patient/client care activities?

_____Yes _____No

If Yes, which of the following represents your primary responsibility:

_____Teaching _____ Administration

_____Research _____Other (specify)

Are you involved in:

Teaching Activities? _____Yes _____No

If Yes, do you: _____Teach academic courses?

_____Supervise students?

_____Present continuing education sessions?

_____Other (specify)

Ongoing Research? _____Yes _____No

Planning and implementing demonstration projects or new treatment approaches?_____Yes _____No

Consultation/Technical assistance (non-direct care services)?_____Yes _____No

Are you involved on planning/advisory committees?

Boards, task forces, etc.? _____Yes _____No

If YES, please answer the following:

	Governmental Organizations		Professional Organizations		Voluntary/Advocacy Organizations	
Local Level	____Yes	____No	____Yes	____No	____Yes	____No
State Level	____Yes	____No	____Yes	____No	____Yes	____No
National Level	____Yes	____No	____Yes	____No	____Yes	____No

Within the last ( ) year(s), have you participated:

On grant review panels or site visit teams? _____Yes _____No

In legislation testimony? _____Yes _____No

In development of written standards of care? _____Yes _____No

Within the last ( ) year(s), how many:

Approved/funded grants have you prepared or helped to prepare?

Publications have you had?

Of these publications, how many were:

Refereed?

Non-refereed (e.g., abstracts, book chapters, etc.)?

_____Books?

Other (Specify)

Date:

Name:

Current Address and Telephone Number

Work:

City:_____ State:_____ Zip:

Phone:( )

Home:

City:_____ State:_____ Zip:

Phone:( )

Permanent contact (someone who will know your address):

Name:

Address:

City:_____ State:_____ Zip:

Phone:( )

Racial Identity:

_____White _____American Indian/Alaska Native

_____Black _____Asian/Pacific Islander

Ethnic Identity: _____Hispanic _____Non-Hispanic

Sex: _____Male _____Female

Highest Degree Held:_____ Discipline of Higher Degree:

While you were in our training program:

Discipline in which you were trained:

Level of degree program in which enrolled or level of post-degree training:

Year you completed our program:

Present Employer:

Position Title:

Type of employment:

_____Direct Service _____Governmental (Local, State, Federal)

_____Private Practice _____Business/Consultative

_____Teaching Institution _____Other (specify)

Are you currently involved in activities (e.g., service, training, research, advocacy, community, etc.) which impact on the health of mothers and/or children? _____Yes _____No

If YES, please answer the following questions in terms of <u>your involvement as related to the area of maternal and/or child health</u>:

Do you spend more then 50% of your time in non-direct patient/client care activities?

_____Yes _____No

If Yes, which of the following represents your primary responsibility:
_____Teaching _____Administration
_____Research _____Other (specify)

For the following, please attach CV, if it provides the information requested, and/or please provide the additional information requested.

Are you involved in;
Teaching activities? _____Yes _____No

If yes, do you:_____ Teach academic courses? Please specify course taught.

_____ Supervise students? Please describe number, type, and context.

_____ Present continuing education sessions? Please list title, date, and place.

_____ Other (specify)

Ongoing research? _____Yes _____No
If yes, please list research project title, collaborators, and funding source.

Planning and implementing demonstration projects or new treatment approaches?
_____Yes _____No If yes, please list project title, collaborators, and funding.

Consultation/technical assistance (non-direct care services)?
_____Yes _____No If yes, please describe.

Are you involved on planning/advisory committees? Boards, task forces, etc.?
_____Yes _____No
If YES, please answer the following:

	Governmental Organizations		Professional Organizations		Voluntary/Advocacy Organizations	
Local Level	____Yes	____No	____Yes	____No	____Yes	____No

State Level ____Yes ____No ____Yes ____No ____Yes ____No

National Level____Yes ____No ____Yes ____No ____Yes ____No

Please list name of organization, level, and nature of involvement.

Within the last ( ) year(s), have you participated:
On grant review panels or site visit teams? _____Yes _____No
If yes, please describe.

In legislation testimony? _____Yes _____No
If yes, please describe.

In development of written standards of care? _____Yes _____No
If yes, please describe.

Within the last ( )Year(s), how many:
Approved/funded grants have you prepared or helped to prepare?
Please list title, source of funding, and amount.

Publications have you had?
Of these publications, how many were:
Refereed?
Non-refereed(e.g., abstracts, book chapters, etc.)?
Books?
Other (Specify)?

Please provide complete reference for each publication.