

**Executive Summary of Leadership Competencies Workgroup,  
October 3-6, 2004, Washington, DC.  
Prepared by Drs. Mouradian and Huebner**

The findings of the Seattle Conference (April, 2004) were presented to a group of MCH Leadership Training Program directors and their representatives at the MCHB All Grantee meeting, “The Power of Partnership,” held in Washington, DC, October 3-6, 2004. Specifically, as part of the All-Grantee Meeting, a Leadership Competencies Workgroup was convened to consider the Executive Summary and the MCH Leadership Competencies developed from the Seattle Conference.

General results of the October Leadership Competencies Workgroup’s discussion included the following:

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

For trainees, the MCH Leadership Training program adds the following to discipline-specific training:

- a. Real world interdisciplinary experience – including learning as a team
- b. Life-span, developmental approach embedded (from reproductive health through infant and child health, adolescent, maternal and family health)
- c. Public-health and population-based orientation: ability to move from the individual level to the population level and back again
- d. Definite focus on vulnerable MCH populations – those with highest disparities (children), CSHCN, etc

For the nation’s maternal and child health community, the Training Program contributes to:

- e. A strong national infrastructure for research, training, outreach, and many collaborative activities to improve the health of MCH populations
- f. Within this national infrastructure and among graduates of the Training Program (who are employed in governmental as well as private settings), the Training Program assures a national network of MCH professionals who are always considering the impact of policies, environmental and other threats and opportunities for MCH populations.
- g. Investment, through children and families, in adult health of the future

Recommended next steps:

1. Reframe definition of MCH leader as “attributes of an MCH leader”
2. Separate and develop further the competency defined as “working with organizations”; keep this distinct from the “management.”
3. Develop further “Module 0: MCH Background information for interdisciplinary trainees.”
4. Develop some type of self-assessment of programs as to their expertise and need for faculty development in the various competency areas
5. Begin creating educational resources in some key gap areas, specifically the MCH-PH context, ethics, negotiation and conflict resolution, management, working with organizations
6. Consider other follow-up activities in the form of white papers, conference calls, meetings, etc as needed to move this agenda forward.

**The Power of Partnership:  
Meeting Today's MCH Challenges through Partnerships  
MCH Training Program**

**Leadership Competencies Workgroup—Meeting Notes  
October 5–6, 2004**

**MCHB Representative:** Laura Kavanagh, MPP

**Facilitators:** Wendy Mouradian, MD, MS; and Colleen Huebner PhD, MPH

**Registered and Other Participants:**

Greg Alexander (Recorder)

L. Francine Caffey

Lisa Craft

Joanne Douthit

Cindy Ellis

S. Jean Emans

Holly Grason

Rita Hohlstein

Nap Hosang

George Jesien

Penelope Leggott

Jonathan Kotch

Toby Long

Elisabeth Luder

Jeff McLaughlin

Jeffrey Okamoto

Dorothy O'Keefe

Donald Orr

Ann Owen

Roz Parrish

Herbert Peterson

John Rau

Gregory Redding

Mark Smith

Dennis Stevens

Sally Stewart

Marsha Sturdevant

Mae Sylvester

Marion Taylor Baer

Brigid Vaughan

Linda Wilson

Others

Karen Eddleman

## **Introduction and Background from the April Leadership Conference**

Laura Kavanagh called the workgroup to order, noting that the participants will have 5 hours to work together to address Goal 4 of the National Plan for Maternal and Child Health Training: “Develop effective MCH [maternal and child health] leaders.”

In April 2004, the University of Washington (UW) sponsored a leadership conference that was initiated to move forward on the concept of MCH leadership. It evolved into a concept of competencies. We will have a facilitated discussion today to look back at that meeting and decide how to move forward. Colleen Huebner said that we are continuing the conversation started in Seattle in April, and Wendy Mouradian noted that we are ready for the next layer of thinking about leadership and leadership training. The goal for today and tomorrow is to work together to suggest action items and recommendations about how to proceed.

The Seattle Conference was convened to bring people together around the topic of leadership. Representatives of the UW School of Public Health, Interdisciplinary Leadership Education in Neurodevelopmental Disabilities project (LEND) and Pediatric Pulmonary Center participated in planning the meeting. Based on suggestions from MCHB, the decision was made to focus the conference on 4 areas:

- Proposing a definition of leadership within the MCH context;
- Determining key leadership competencies for trainees and for faculty;
- Identifying tools, curricula, and experiences to develop leadership; and
- Determining methods to measure process and outcomes of MCH leadership training.

After coming up with the list of key leadership competencies, the Planning Committee assigned people from a broad spectrum of disciplines to 12 working groups. All the participants had done some advance work to consider experiences in which they had applied a specific MCH leadership competency. In the working groups, the participants came together to present their experiences, explore the individual competencies, and identify some relevant process and outcome evaluation measures. On the second day of the conference each working group was asked to examine the competency from an overarching, intuitive level. In other words, they asked, “What does this competency look like?”

Each group came up with a summary of the specific competency. Dr. Mouradian noted that the Seattle Conference did not get down to specific training curricula or outcome measures for each of these competencies. Different working groups got to different points.

The output of the Seattle Conference was a complete report. The executive summary from that report was distributed. It consists of about 25 pages and includes some supplementary material as well. The full report and executive summary are posted on the

MCHB Training Program Website at <http://www.mchb.hrsa.gov/training/events-2004-AllGranteeMTG.htm> .

Dr. Mouradian said that implicit in the Seattle Conference discussions were the background and context of MCH values. First, we understood that the discussion of these competencies would be cross-cutting and interdisciplinary. The competencies will be broadly relevant. Second, the competencies will be set in the context of MCH values; that is, they will be:

- Population focused, prevention oriented;
- Family centered;
- Culturally competent;
- Community based;
- Focused on vulnerable (MCH) populations;
- Reflective of the fact that children are different from adults.

Dr. Mouradian showed a pie chart depicting the affiliations of the Seattle attendees, from the Seattle Conference evaluation (contained in the full report). Fifty-three long-term training programs were in attendance, representing 11 of the 12 disciplines.

### **MCH Leadership Competencies**

After the Seattle Conference, Drs. Huebner and Mouradian reviewed written outputs, flipcharts, reports the participants had provided, and transcripts from the conference. From this information, they were able to distill 11 key MCH leadership competencies (See Table I, next page). As they further sorted and shifted, they came up with a paradigm to divide the competencies into core competencies and applied competencies. Dr. Mouradian said that the four core competencies (communication skills, critical thinking, internal process/self-reflection, and ethics/ professionalism) are cross-cutting; they came up in every discussion group. They are the required “raw materials” that should be present in trainees when they enter the program. Some of these are inborn or instilled early in life, or the result of specific experiences. It is our job to find trainees who possess these competencies to some extent and then to nurture and build on those core competencies. The applied competencies are mentoring; cultural competency; evidence base/translation of science; negotiation/conflict resolution; management skills; constituency building; and policy and advocacy. The applied competencies are more complex skills that need to be brought out and emphasized. People need training on these applied competencies. A competency consists of intrinsic capacities that trainees bring, plus abilities, knowledge, and skills.

They then listed the competencies, and they were correlated with related competencies. Competency 0 is knowledge of historical and legislative context of MCH. Every trainee should have some background in public health. The competencies were ranked in order of increasing complexity. All of these competencies are part of what an MCH leader does. They are acquired throughout a career.

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

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

*b Acquiring ethical knowledge is felt to be a secondary application; moral purpose and integrity are felt to be more intrinsic attributes.*

*c These were collapsed due to the similarities of topics covered and the lack of sufficient facilitators.*

### **Discussion at the October meeting:**

Some participants expressed concern about separating out the four core competencies because during training programs, trainees make great leaps in progress in these areas. To say that these are intrinsic skills might cause them to be deemphasized in training. Dr. Mouradian mentioned that in 1987-88, there was a two-step workshop on leadership that brought together LEND groups and others. They looked at how to identify and accept trainees. There was much overlap among core competencies. Another person said that these are so basic that you must ensure that your trainees have these. This hierarchy (of leadership competencies) is empirically validated by the applicant reviews they do in their program, according to another participant. Yet another participant said that when they look back at their former trainees that they can see that they were very strong in the core competencies.

Dr. Huebner said that we could make the point that we might see the core competencies already present in a rudimentary fashion in our entrants, but we are obliged to nurture them and focus them on MCH. Dr. Mouradian said that, from a recruitment standpoint, candidates should have potential in the four core competencies or else they are probably not going to become MCH leaders. Nevertheless, this list is very basic and cannot represent the richness that we need to ensure that our trainees have.

One participant said that regarding management skills that he is a stickler about people having competency in financial management when they enter training.

Another participant suggested including teaching as a separate competency. Dr. Mouradian noted that education is identified as a target area (faculty development). You need to have faculty who can impart information to trainees. There was some concern expressed by the participants because many believed that teaching is such an important competency. Dr. Mouradian made that point that the facilitators are open to modifying this hierarchy. Perhaps the mentoring competency could be modified to read “teaching and mentoring.” One person said that teaching has nothing to do with leadership. He said it is not necessary to be a good teacher to be a good leader. He suggested that teaching not be listed as a core competency. Someone else said that perhaps teaching could be included under the communication skills competency (e.g., writing, teaching). According to one participant, if you cannot communicate, you cannot teach either. But, according to Dr. Mouradian, it is possible to be able to communicate without being a teacher. One man suggested rewording competency #5 to read as “mentoring/teaching.” Maybe the word “teaching” should be replaced with “influencing.”

One person made the point that leaders must be learners. They do not always need to be out in front. That should be reflected in the competencies. They should be able to learn and change.

Someone else asked if MCH leaders being considered only in the context of academic settings? Dr. Mouradian responded that competencies should be generic to a variety of settings: “We need to have our competencies cross-cutting to the extent that they apply in a variety of settings.

Several people expressed thoughts along the lines of, “Leadership involves mobilizing people.” People can exercise leadership from positions of authority or not involving authority. It would be useful to define what we mean by “to lead.”

### **Definition of MCH Leadership**

Dr. Mouradian offered the following proposed definition of MCH leadership, which came out of the Seattle conference but only after all the competencies were identified and the hierarchy and interrelated competencies were determined:

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** and **ethics** 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 (and **policy/advocacy for MCH populations**). The MCH leader is also committed to sustaining an infrastructure to recruit, train, and mentor future MCH leaders to ensure the health and well-being of tomorrow’s children and families, **working across health sectors and organizations to accomplish these goals**. 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.

## **Discussion at the October meeting:**

One participant said his initial reaction is that this definition does not explain what it means “to lead.” Change is a contact sport. Leadership means taking a program from the status quo to something better, more humane, etc. This definition uses many verbs, but we need a sense of how a leader brings an organization and its people to a new level, takes on new challenges, meets emerging needs, and so forth.

Another person asked about including a sense of passion or “fire in the belly.” Dr. Mouradian responded that this quality is embodied in many of the competencies although it is not explicitly laid out in the definition.

Someone said that what is missing here is a sense of vision. Several people agreed, and one person mentioned the possibility of using self-assessments to help trainees develop vision and look to the future.

Dr. Mouradian said that one of the competencies (constituency building) incorporates the ability to articulate a clear vision. The vision of a leader should be part of an MCH competency. Another person said we may want to frame it in that way. There are many popular definitions of leaders; maybe they could be adapted and reframed along the lines of “An MCH leader is someone who influences or moves people, organizations, etc., toward a vision...” What is presently the definition seems subservient to that definition; it appears to be an interesting array of capabilities or attributes that MCH leaders should have. Perhaps, suggested one participant, “We should not lock leaders into our list of competencies. The list of required competencies is likely to change. Leaders should be able to define competencies anew.”

Someone else distinguished between authority and leadership.

## **Definition of Competency**

Dr. Mouradian explained that the starting point for the summary of each competency discussed in Seattle was to define each competency in terms of knowledge, attitudes, skills, and abilities. After doing this, Drs. Mouradian and Huebner then looked at a trend in medical education to think about moving away from training to competencies to training for capability (the ability to adapt to change, generate new knowledge, and continue to improve their performance (Fraser and Greenhalgh, 2001). Drs. Mouradian and Huebner, felt the notion of “capability” was closer to what we are trying to achieve in MCH leadership training – the ability to respond, at the individual and systems levels, effectively and quickly to new challenges.

A competency consists of intrinsic capacities that trainees bring, plus abilities, knowledge, and skills. How do we as training programs go further in these areas?

This is related to a theme that arose in the previous meetings of LEND programs (1987, 1988), revisited in Seattle (April 2004) and again at this meeting (October 2004). That is,

we are training leaders for the future and we don't know what the future is. The competencies of today may not be the competencies of tomorrow. Nevertheless, the rich, interdisciplinary discussion at the Seattle Conference may have led to a definition of leadership that will last a long time because of how it was synthesized. As long as health policy and health care involve people working with people, these competencies will outlast change. Also, we believe that the moral purpose and professionalism issues should outlast the change in paradigms from today to tomorrow. It is important to be able to go back to core values. The discussion at the Seattle Conference was not context-bound. We came up with discussions that relate to the future. These MCH leadership competencies get us on a road that is less tied to our individual contexts and disciplines.

Dr. Mouradian mentioned that several articles from the 2001 British Medical Journal looked at capability, moving beyond competency. Capability may be even harder to measure. In addition to all the discipline-specific things that must be addressed in a program, now we have to integrate all this leadership stuff. We can think about an experience that captures many of these competencies at once. That's called a capstone experience: a cumulative experience in which students synthesize, integrate, and apply knowledge. Most programs offer such experiences (e.g., practica) to give trainees an opportunity to practice, learn, and demonstrate. Perhaps such capstone experiences can be modified easily to encompass some of these competencies. Use self-assessment to help trainees fine-tune their capstones in keeping with their strengths and weaknesses. You are probably doing most of these things already, and it is just necessary to recast the capstone and add some areas of emphasis. That would be one way for training programs to incorporate MCH leadership competencies without adding to the training burden. One concern expressed by a participant is the need to include some theory in leadership development. Dr. Mouradian agreed that trainees do need some background information. You can't do it all at once, but some areas lend themselves to additional faculty development in the next year or two.

Dr. Huebner said that no one person will be expert in all the competencies. But, you should have all this expertise on your team.

One person asked whether teaching leadership is different from teaching management skills. Dr. Mouradian said that you can't manage change without strategic/systems thinking. That's the kind of fleshing out that needs to happen today and tomorrow; that's the kind of input we want from you.

Ms. Kavanagh noted that much of the discussion at the Seattle meeting focused around making more of what we are already teaching more explicit to trainees, explaining why we are doing what we are doing as faculty members. In addition, due to the diversity of training programs and types of trainees, competencies should be viewed as developmental, some trainees will become more knowledgeable in an area, and others will become proficient. Not everyone will become proficient in all areas. To be an agent for change, you can put together a team for change.

Someone else asked if the idea is that we develop a leadership curriculum that would include these competencies within modules. Ms. Kavanagh said that the initial plan, as outlined in Goal 4 of the National MCH Training Strategic Plan, was to develop a model curriculum. This concept has evolved over time, and we may decide to move away from the concept of developing a model leadership curriculum. Whatever model we choose, we need to make sure that all MCHB supported leadership training programs are explicitly including leadership training as part of their curricula.

Someone else said that we are trying to imprint people with a roadmap for the rest of their life. Another suggested going to an assessment model to find out where the trainees are in terms of their competencies and then move them forward. If we can posit for them the next set of experiences or knowledge they need to have, we can help them continue on the leadership trajectory.

### **The Charge to the Discussion Groups**

At this point, the large leadership workgroup divided into four smaller discussion groups. Each group was assigned to review two or three competencies to offer substantive comments and identify gaps. The groups were provided with the one-page descriptions that were Drs Mouradian and Huebner's synthesis after the Seattle Conference discussions. The current exercise with October conference participants was not meant to be prescriptive; it constituted the next layer of feedback. Then, she asked the subgroups to address several more questions:

1. With the competencies in mind, do you have any additional thoughts about the definition of MCH leadership?
2. What is the difference between MCH competencies and MCH leadership competencies? (Are they different conceptually or is it a matter of degree?)
3. What is the value-add of MCH leadership training?
4. What should our next steps be?

Ms. Kavanagh asked for opinions about whether this leadership training workgroup should reconvene. Most people said it was premature to discuss this without having worked within their discussion groups. Everyone was interested in continuing in some fashion but was open-ended about what mechanism to use.

### **Day 2 Discussions**

Recap of Day 1 Key Points of Discussion:

- A. MCH leader definition
  - i. Reframe the definition as attributes, actions, not just a rewording of the competencies
  - ii. Include a greater focus on vision and purpose
  - iii. Passion, "fire in the belly"
  - iv. Define leadership or "to lead"
- B. MCH competencies

- i. Consider adding teaching to the mentoring competency or the communication competency
  - ii. Be explicit about teachable skills (e.g., in communication?)
  - iii. Management versus leadership, importance of finances
- C. Other comments
- i. Role of hope, optimism, emotional intelligence
  - ii. Many of the competencies discussed here are similar to the MCH competencies, should they be combined?

There was some talk about recasting the MCH leadership “definition” as leadership “attributes” and/or actions. The participants also discussed adding to the definition/attributes some explicit references to teaching and lifelong learning. Others asked about inserting references to capability, curiosity, flexibility, and adaptability. Someone said that we should train to capability and not to competency.

One participant recommended against taking a prescriptive approach: “It almost seems that we are telling them what they should think and how they should act.”

Further discussion on including teaching with the mentoring competency led one participant to state that mentoring is totally different from teaching; mentoring is beyond imparting knowledge; it is about supporting someone’s development. Mentoring also involves an internal process because a mentor must give up something, too (presumably the mentor’s own agenda, which must shift to identifying the mentee’s goals and objectives.)

Dr. Mouradian said that she does not think there is a great deal of difference between an MCH competency and an MCH leadership competency. No matter where you are in the hierarchy, leadership is involved. Anyone in MCH should have leadership qualities. Maybe we should call it “Leadership for MCH Professionals,” suggested one participant. Dr. Mouradian made two comments: (1) Most training programs within MCHB are leadership programs; and (2) We assume discipline-specific expertise for MCH leaders; that is why MCH expertise is not mentioned in the definition.

Are we training leaders who are going to be in the MCH field, or are we training MCH leaders? One participant commented that not everyone is a leader. In most situations, one or two leaders emerge and everyone else follows along. If you are a great clinician, are you a leader? No, not necessarily. It is only when you move to the next step of influencing people, practice, or policy that you step into the leadership role. Leadership is influencing others.

One participant offered this definition for an MCH leader: One who promotes, influences, and moves persons, practices, and policies toward the MCH vision.

Someone else said that leading is a series of acts. In our interactions with others, we choose whether to act as a leader. She said her definition of a leader is someone who

mobilizes people to attack problems. When you are in the arena dealing with tough problems, you have to do some learning and figuring out. You are often facing a loss, so this is difficult. She cited the example of a clinician leading a family to prepare for the loss of a loved one.

Dr. Mouradian asked about what is central to all leadership. What leadership qualities should any MCH professional have? We are training people who are MCH professionals (assumes competencies are present) to lead in the future or to improve their capacity for leadership.

Ms. Kavanagh said that some trainees may not initially describe themselves as MCH professionals; they may identify more with their discipline than with MCH as a profession. One outcome that we want to achieve in MCH Training programs is to expose all trainees to MCH leadership competencies, that is, competencies that are grounded in the MCH history and philosophy. We want to distinguish MCH leadership training from generic leadership training that one might get in a business school, for example.

One person stated that the clinical setting has challenges, but it is an ideal place to teach about systems. That is what distinguishes public health programs. Another said that it is clear that what you are trying to do is define in an individual these competencies that cover all possibilities. He said that we do better in teams than we do as individuals. Dr. Mouradian agreed, saying that not everybody is going to have leadership qualities, but somebody on your team better have. The need for collaboration is increasing as we accumulate more expertise.

Another participant objected, saying that she feels nervous when she hears that everybody is a leader all the time. Everyone has some potential to step up for particular projects, but there is a tension around this issue. There is a difference between occupying an authority position and exercising leadership. Leadership is not a job title.

This is not a one-shot deal; this is a process, said one individual. We have to motivate people. There are different levels of leadership within an individual, and there are different levels of leadership across individuals. Colleen Huebner said that we have been hearing more about clinicians and less about public health. The public health approach has gotten lost here. Others disagreed with her statement, saying that they felt just the opposite. Public health staff are probably less likely to hear about systems problems, for example, how families have trouble getting care through systems.

## **Findings of the Discussion Groups: Day 2**

### ***Group 1—Communication Skills, Cultural Competency, Negotiation/Conflict Resolution***

Roz Parrish  
Colleen Huebner  
Elisabeth Luder  
Jean Emans  
Mae Sylvester

This group’s discussion reinforced the impression that Communication Skills need to be further developed in trainees. The group also discussed Cultural Competency as it relates to the classroom teaching situation. Cultural issues come out in teaching content. The group also addressed the issue of how “race” is used in public health. They recommended developing a list of Web resources related to cultural competency.

In the area of Negotiation/Conflict Resolution, the participants agreed that most people lack expertise in this area. It was identified as an important area for faculty development.

In terms of the value-add of MCH leadership training, the group agreed that a main strength is the interdisciplinary nature of the training. It may be a costly model of care but it is the learning in that model that is important. They also talked about the MCH population in terms of clinical needs and the public health.

### ***Group 2—Evidence Base/Science Translation, Critical Thinking***

Holly Grason  
Greg Redding  
Laura Kavanagh  
Jeff McLaughlin

This group validated many of the same issues especially around the value-add of MCH leadership training. They specifically talked about the strength of the interdisciplinary approach. The public health perspective is another value-add.

In general, they liked what was written about the Evidence Base/Science Translation competency. They indicated that some word-smithing is required. They also suggested including a list of operational issues with the competencies that would provide examples of teaching methods for that competency in both clinical and public health settings. They recommended using self-assessment for faculty and trainees. No one has strengths across *all* these areas. They also spoke about pilot-testing the curricula. They said that it is important to emphasize that many MCH training programs are already providing training in many of the competency areas, programs just need to be more explicit about what they are teaching. We are not suggesting that they implement an entirely new curriculum. The group did not want training programs to feel overwhelmed by these competencies.

### ***Group 3—Internal Process/Self-Reflection, Ethics/Professionalism, Mentoring***

Rita Hohlstein  
Lisa Craft  
Marion Taylor Baer  
Francine Caffey  
Wendy Mouradian  
Jonathan Kotch

This group also did some word-smithing. These are important issues. Internal reflection is important part of leadership, but it is not addressed adequately at present. We need to teach and train to this gap. Some curricula are already available.

In terms of the value-add of MCH leadership training, this group talked about interdisciplinary team function. Insofar as ethics and moral underpinning, this group noted that nobody else has the reproductive lifecycle viewpoint that MCH professionals do. It is a preventive approach across a developmental lifecycle. They also talked about the family-centered nature of the MCH field. Interdisciplinary means being involved in other groups and making use of public health tools across the lifecycle.

There was some discussion of MCH professionals being a response team that identifies, responds, and assesses threats (e.g., disease, policy). Nobody else owns that in the same way. MCH professionals have the ability to critically analyze impacted policies, environmental threats, etc., to the MCH population.

### ***Group 4—Constituency Building, Policy/Advocacy, Management Skills/Working with Organizations***

George Jesien  
Nap Hosang  
Linda Wilson  
Sally Tom

This group did some word-smithing, suggesting that the opening paragraph on Management Skills be simplified.<sup>1</sup> They also proposed adding to the Management Skills competency to say that an MCH leader uses good business practices to further MCH goals and visions. The group suggested some wording along the lines of “She or he values and builds on the contributions of others to effect...” They also stressed the importance of the MCH leader being able to work with organizations and systems.

For the Policy/Advocacy competency, the introductory sentence defines policy, but another sentence is needed to define advocacy (e.g., activities carried out on behalf of policies or constituencies). Advocacy needs to be thought of at the family level, level of

---

<sup>1</sup> All the groups submitted their editorial changes to Colleen Huebner.

policies, state and federal law. They also did some word-smiting on the competency description.

In terms of the value-add of MCH leadership training, this group echoed the thought about interdisciplinary nature of MCH programs. They also discussed the differences between how people from the public sector think about problems compared to those in the private sector. In business, you have a measure of success—profit. We need to rely on discussion to set resources. MCH leaders need skills to be part of those discussions and set policy and procure resources. They need skills for clarification of resource allocation decisions, which involve political, financial, and ethical aspects. It is different from the business world. It is for the MCH population and spans both nonprofit and public sectors. This concept must be embedded in the values of the MCH discipline.

Finally, when contrasting MCH competencies and MCH leadership competencies, this group suggested that certain competencies are unique to leaders, namely mentorship, professionalism, and ethics. Most of the competencies listed are generic. The values are specific to MCH, but the tools are generic leadership tools.

***The Big Picture: Summary of key points of discussion***

- Although not perfect, the MCH leadership competencies comprise a useable, conceptual framework that is broadly applicable.
- Although some competencies are more core than others, we must not lose teachable aspects, even in core competencies.
- There is cross-over among the competencies.
- We need to give high priority to some resource/training gap areas, namely negotiation/conflict resolution; internal process/self reflection; ethics; and the MCH knowledge base across the training program categories and types of trainees. We need to identify resources to train on these competencies and develop faculty.
  
- *Value added:*
- For the value-add of MCH leadership, as a whole, there is a real interdisciplinary emphasis across the programs in terms of how the team functions and so forth. There is a focus on MCH vulnerable populations, and there is a public health perspective by being able to go between individual patients and public health as a result of complex bio-psychosocial interactions. The latter is the driving force.
- MCH programs offer a preventive and public health approach across the reproductive lifecycle.
- We are part of an MCH national “team” that is able to anticipate, analyze, and respond to emerging challenges for MCH populations.
- One hundred forty programs is an academic infrastructure that represents a huge value.
- We influence other groups.

***Next Steps:***

1. Begin negotiations to prioritize and initiate a process to develop the competencies further, and share them widely.
2. Provide operational examples of teaching methods for public health and clinical programs.
3. Develop self-assessment tools for faculty/trainees.
4. Pilot a curriculum.
5. Define and share what is already in place in many competency areas in MCHB supported training programs.
6. Share best practices regarding integrating MCH leadership competencies into capstone projects.
7. Revisit the proposed definition of MCH leadership, add passion, vision, list attributes instead of restating the competencies.

