Maternal and Child Health Leadership Competencies

VERSION 3.0

MCH Leadership Competencies Workgroup (Editors)

Table of Contents

Introduction

AN MCH LEADER INSPIRES AND BRINGS PEOPLE TOGETHER

TO ACHIEVE SUSTAINABLE RESULTS

TO IMPROVE THE LIVES OF THE MCH POPULATION.[1]

To be a leader in Maternal and Child Health (MCH) requires specific knowledge, skills, personal characteristics, and values. The leadership competencies described in this document and drawn from both theory and practice are designed to support and promote MCH leadership. The document is targeted to MCH interdisciplinary training programs and practicing MCH professionals. The document:

▲ Defines MCH leadership.

▲ Identifies core MCH Leadership Competencies.

▲ Outlines the knowledge and skill areas required of MCH leaders.

▲ Provides a conceptual framework for the development of an MCH leader.

▲ Describes how MCH Leadership Competencies might be used by a variety of audiences.

Who Are MCH Leaders?

An MCH leader is one who understands and supports MCH values, mission, and goals[2] with a sense of purpose and moral commitment. He or she values interdisciplinary collaboration and diversity and brings the capacity to think critically about MCH issues at both the population and individual levels, as well as to communicate and work with others and use self-reflection. The MCH leader possesses core knowledge of MCH populations and their needs and demonstrates professionalism in attitudes and working habits. He or she continually seeks new knowledge and improvement of abilities and skills central to effective, evidence-based leadership. The MCH leader is also committed to sustaining an infrastructure to recruit, train and mentor future MCH leaders to ensure the health and well-being of tomorrow's children and families. Finally, the MCH leader is responsive to the changing political, social, scientific, and demographic context and demonstrates the capability to change quickly and adapt in the face of emerging challenges and opportunities.[3]

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[1] Adapted from: George, B. (2006, October 30). Truly authentic leadership. *U.S. News & World Report*, 52.

[2] Maternal and Child Health Bureau (MCHB). *Strategic Plan, FY 2003–2007*. Retrieved February 20, 2007, from MCHB Web site: http://www.mchb.hrsa.gov/about/stratplan03-07.htm#1.

[3] From the April 2004 Future of MCH Leadership Training Conference.

Use of the MCH Leadership Competencies

The MCH leadership competencies can be used in a variety of ways to support and promote MCH leadership. These include the following:

1. **Frame training objectives for the MCH Leadership Training Programs.** It is the responsibility of MCH leadership training programs to ensure that program graduates have the foundation necessary to work within a variety of professional settings to contribute to the health and well-being of our Nation's most vulnerable population groups and to inspire others to do likewise. The core leadership competencies can be used by all academic MCH training programs to help frame their own training objectives.

2. **Measure and evaluate leadership and training for leadership.** MCH leadership competencies can be used to initiate and guide discussion about the measurement and evaluation of MCH leadership and of quality training.

3. **Cultivate and measure competencies within the current MCH workforce.** MCH leadership competencies can be used as a tool to strengthen the leadership abilities of the existing and future MCH workforce. The framework provided by the MCH leadership competencies can assist local and State MCH agencies in orienting new employees without MCH backgrounds to the goals and methods of MCH. The leadership competencies can also guide ongoing continuing education efforts to promote the knowledge and skills necessary for effective leadership.

4. **Sustain and grow MCH leadership throughout the health care system.** The MCH Leadership competencies allow State and local health agencies and organizations and graduate MCH training programs to assess and promote leadership capacity.

Rationale for Development of MCH Leadership Competencies

It is often said that a Nation's health is best measured by the health of its most vulnerable citizens: its children. Promoting and ensuring their health and wellness requires the strong presence of MCH leaders at the national, State, and local levels. These are individuals with the vision, expertise, and skills to provide the leadership needed to design and implement policies and programs to assure that children grow into competent, independent, nurturing, and caring adults.

The importance of MCH leadership is emphasized in the strategic plan for the Maternal and Child Health Bureau (MCHB) and throughout the MCH Training Program. For many years, MCHB and the MCH Training Programs have had an interest in defining MCH leadership better and measuring whether those trained through the program became leaders.[4] The need for MCH leadership competencies was also emphasized in the development of the MCH Training

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[4] See Appendix A for a detailed listing of MCH Leadership Activities.

Program's 5-year strategic plan, the National Plan for MCH Training, 2005–2010.[5] Representatives from both the MCH academic and practice communities recommended that the MCH Training Program develop MCH Leadership Competencies as one of its strategic goals.

History of Development of MCH Leadership Competencies

The development of the leadership competencies has been thorough, comprehensive, and inclusive. The following summarizes steps used in this process.

- ▲ **April 2004.** At a conference entitled Future of MCH Leadership Training,[6] held in Seattle, Washington at the University of Washington, representatives from many of the MCH Training programs came together to draft MCH Leadership competencies, the critical knowledge and skill areas that they felt were necessary to develop MCH leaders.

- ▲ **Fall 2004.** The draft competencies developed in Seattle were further refined later that year at the MCHB All Grantee Meeting in Washington, DC.

- ▲ **Early 2005.** The MCH Competencies Working Group was formed, composed of individuals representing MCH training programs, Association of Maternal and Child Health Programs, and CityMatCH. This group refined the competencies and developed a revised draft.

- ▲ **Fall 2005–spring 2006.** The revised draft was shared at grantee meetings throughout this period and all MCH training programs were asked to provide comments about the MCH Leadership Competencies.

- ▲ **Winter 2007.** Comments from the field were reviewed by the Workgroup. This document reflects the suggested changes from the field and subsequent meetings with the Workgroup.[7]

The result of this work was 94 competencies, clustered in 12 domains. In the spring of 2008, a method of expert consensus, known as a modified Delphi Technique, was conducted to begin the process of validating the competencies. The Delphi technique relies on the opinions of experts to determine how important particular items are to a construct or domain of interest. The goal of the technique is to achieve consensus, or agreement, about items that are considered to be important or very important. A panel of MCH experts was identified by MCH leadership. These experts were contacted via e-mail and asked to participate in the two-phase validation process. Forty-

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[5] Maternal and Child Health Bureau (MCHB). *National MCH Training Strategic Plan*. Retrieved February 20, 2007, from MCHB Web site: http://www.mchb.hrsa.gov/training/strategic_plan.asp.

[6] Maternal and Child Health Bureau (MCHB). (2004). MCHB Conference Webcasts. Retrieved February 20, 2007, from Center for the Advancement of Distance Education Web site: http://www.cademedia.com/archives/MCHB/leadership2004/

[7] Workgroup members are Gwendolyn Adam, Mary Balluff, Karen Edwards, Anita Farel, Al Hergenroeder, Colleen Huebner, George Jesien, Laura Kavanagh, Kathy Kennedy, Mark Law, Crystal Pariseau, Virginia Reed, Greg Redding, Karyl Rickard, and Phyllis Sloyer.

seven individuals responded, indicating that they would participate. Of these, 38 completed Phase 1 of the process and 35 completed Phase 2. Complete details of the validation process and the resultant analysis and recommendations may be found in the report: *Validating the MCH Leadership Competencies: Results of a Modified Delphi Procedure*[8].

During the two phases of the modified Delphi Technique, participants noted that the number and lack of distinctiveness of many of the competencies was problematic, commenting in particular that the current number of competencies was larger than could be used practically. Thus, a decision was made in consultation with MCH leadership to decrease the number of competencies, focusing on those lacking consensus as targets for elimination. Applying the criteria described in the report, 19 items were eliminated, reducing the number of competencies to 75. Three additional items were eliminated due to redundancy. Thus, the Version 3 set of MCH Leadership Competencies consists of 72 items clustered in 12 competency domains.

These competencies are the result of an iterative and inclusive work-in-progress that was based on the literature on leadership (from the business, military, and social science contexts),[9] and the wisdom and experience of current MCH participants and leaders.

Conceptual Framework for the MCH Leadership Competencies

An early task of the groups was to determine what concepts should frame the development of the competencies. Many conceptual frameworks for leadership have been described in the literature, and while these are undeniably useful, Workgroup members emphasized the importance of the following concepts in understanding MCH leadership.

- ▲ Leadership in health care is contextual in nature.
- ▲ MCH leaders must address an array of issues that are specific to the MCH population groups.
- ▲ Leadership should be viewed as a developmental progression of increasing influence.

A wide array of factors influences both the health status of individuals and groups and the ability of leaders to affect health policies, programs, and outcomes. These factors can include the health practices of individuals and groups, the availability of health care resources, and competing social and political priorities.

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[8] Reed, Virginia A. (April 12, 2009). *Validating the MCH Leadership Competencies: Results of a Modified Delphi Procedure. http://leadership.mchtraining.net/*

[9] See Appendix C for leadership references and resources.

The developmental progression of leadership is of particular importance to those involved in the professional and continuing education of MCH health professionals. Leadership ability grows as the knowledge, skills, and experience of the individual expands and deepens. The Figure 1 graphic illustrates the widening circles of influence that leaders experience as they develop – from self to others to the wider community.

▲ **Self.** The leadership process begins with the focus on self where leadership is directed at one's own learning through readings, instruction, reflection, and planned and serendipitous experiences. Individuals increasingly learn to direct their actions and growth toward specific issues, challenges, and attainment of desired goals.

▲ **Others.** The next sphere is labeled others where leadership extends to coworkers, colleagues, fellow students, and practitioners. The behavior and attitudes of others are influenced and possibly altered through the actions and interactions of the individual. Leadership and influence can remain at this level of impact for long periods of time. There are wonderful examples of how teachers have affected the life course of students or how clinicians or public health workers have affected the lives of children and families.

Figure 1.

▲ **Wider Community.** Leadership also can extend to a broader impact on entire organizations, systems, or general modes of practice. These wider areas of impact and influence require additional skills and a broader based understanding of the change process and the factors that influence change over time. Examples of this level of leadership are MCH professionals mobilizing communities to improve the local system of health care for pregnant women or influencing policy at the State level to improve reimbursement to MCH providers.
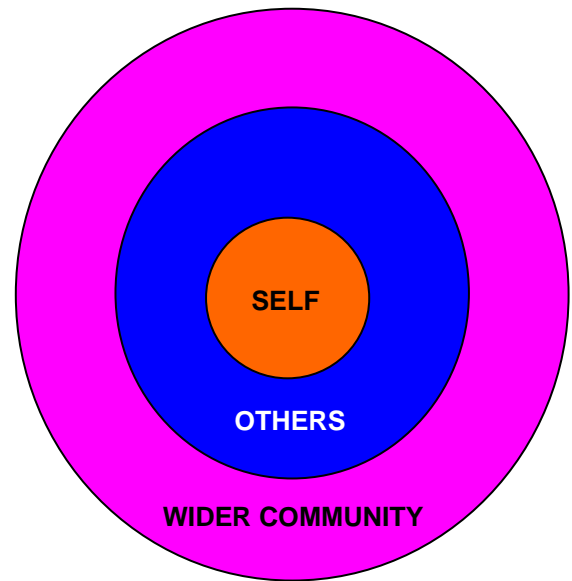
The following leadership competencies are presented in a progression from self to wider community which demonstrates the widening contacts, broadening interests, and growing influence that an MCH leader can experience over a professional lifetime.

Also important to the framing of the competencies is the understanding that (1) leadership can be developed through learning and experience; (2) leadership can be exerted at various levels within an organization or agency and at the local, State, or national levels; and (3) leadership opportunities change over time. Finally, it is understood that MCH leaders build their expertise

upon a base of specific disciplinary knowledge[10] and MCH knowledge that includes understanding and applying the overall mission and vision of MCH. A useful framework for thinking about the MCH mission and types of MCH services and systems that an MCH leader can impact is presented in the MCH Pyramid, Appendix B.

The MCH Leadership Competencies

Twelve MCH leadership competencies are presented here and organized into the three categories described in the conceptual framework. These categories include:

    I. **Self**

        1. MCH Knowledge Base

        2. Self-reflection

        3. Ethics and Professionalism

        4. Critical Thinking

    II. **Others**

        5. Communication

        6. Negotiation and Conflict Resolution

        7. Cultural Competency

        8. Family-centered Care

        9. Developing Others through Teaching and Mentoring

        10. Interdisciplinary Team Building

    III. **Wider Community**

        11. Working with Communities and Systems

        12. Policy and Advocacy

Each of the 12 competencies includes a definition of the competency, knowledge areas, and basic and advanced skills for that competency.

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[10] Each MCH discipline (e.g., public health social work, pediatrics, public health, nutrition, nursing, psychology, pediatric dentistry, etc.) has defined its own discipline-specific competencies through its professional organizations and accrediting bodies. These may overlap, in part, with this list of 12 competency areas.

Next Steps

Since the initial release of *MCH Leadership Competencies 2.0* , the competencies have been disseminated at Training Program grantee meetings and made available on the on the MCH Leadership Competencies Web site, www.leadership.mchtraining.net.

The MCH Leadership Competencies Web site will continue to house the Competencies and serve as a place for you share your comments and experiences. The Web site offers the following:

▲ **Bulletin board.** Here you can comment on the usability, clarity, and functionality of the competencies. You also can provide your own examples of training mechanisms and resources.

▲ **List of the Competencies.** This includes definitions, knowledge, and skill areas.

▲ **Training Experiences.** Available is a list of training opportunities and a place where grantees and others can add their own suggestions.

▲ **Measurement Section.** Included here are suggestions for how to create measures, a resource section, leadership literature review, and many more helpful items.

It has been evident through the MCH Training Program annual progress reports that efforts have been undertaken by programs across the nation to determine how best to use the competencies to improve the quality of our training programs and of our practice in MCH. We hope that you will share with us how you are using the MCH Leadership Competencies in your work and your thoughts on the revised Competencies . Examples of how the Competencies could be used follow:

▲ Current MCH training programs could choose to focus on one competency per year as they assess their curriculum.

▲ Local health departments could use the competencies to orient new staff members or to incorporate into job descriptions.

▲ Faculty members or practicing MCH professionals might use the competencies to identify areas in which they would like to receive continuing education.

Finally, this document represents the continuation of a dialogue regarding MCH leadership competencies and MCH leadership. We look forward to your continued involvement.

MCH Leadership Competencies

Twelve MCH leadership competencies are presented here, organized into three categories: Self, Others, and Wider Community. Each of the 12 competencies includes:

- ▲ A definition of the competency.

- ▲ Knowledge areas for that competency.

- ▲ Basic and advanced skills for that competency.

I. Self

MCH Leadership Competency 1: MCH Knowledge Base

DEFINITION

MCH is a specialty area within the larger field of public health, distinguished by:

- ▲ Promotion of the health and well-being of all women, children, adolescents, fathers, and families, especially in disadvantaged and vulnerable populations

- ▲ A life cycle approach to theory and practice. The life cycle framework acknowledges that there are distinct periods in human development that present both risks and opportunities to intervene to make lasting improvements.[11]

MCH focuses on individuals and populations, on health promotion and prevention, and on family-centered systems of care in communities.

KNOWLEDGE AREAS

Through participation in the training program a participant will know:

- ▲ The history and current structure of the key MCH programs serving women, families and children.

- ▲ The core values and strategic objectives that necessitate a special focus on the MCH populations. These core values and strategic objectives include a focus on prevention,

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[11] World Health Organization. *Life-cycle approach: A framework to identify vulnerabilities and opportunities.* Retrieved February 1, 2007, from World Bank Web site:
http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTCY/0,,contentMDK:20243956~menuPK:565264~pagePK:148956~pi PK:216618~theSitePK:396445,00.html

individuals and populations, cultural competence, family-centered and community-based systems of services, elimination of health disparities, and evidence-based practice.

▲ The services available through major MCH programs and their limitations and gaps.

▲ The underlying principles of public health and population data collection and analysis and the strengths, limitations, and utility of such data.

▲ How programs that focus on particular populations or communities and those that focus on delivery of individual health services work synergistically to improve the health of the Nation.

SKILLS

Basic. Through participation in this program, a participant will:

1. Use data to identify issues related to the health status of a particular MCH population group.

2. Describe health disparities within MCH populations and offer strategies to address them.

Advanced. With more experience and building on the basic skills, MCH leaders will:

3. Demonstrate the use of a systems approach to explain the interactions among individuals, groups, organizations and communities.

4. Assess the effectiveness of an existing program for specific MCH population groups.

MCH Leadership Competency 2: Self-reflection

DEFINITION

Self-reflection is the process of examining the impact of personal values, beliefs, styles of communication, and experiences. This process develops a deeper understanding of one's culture, personal and cultural biases, experiences, and beliefs as these may influence future action and learning. Self reflection is a process that can be used to maximize personal satisfaction and strengthen MCH commitment.

KNOWLEDGE AREAS

Through participation in this program, a participant will know:

▲ The value of self-reflection in understanding personal beliefs, styles of communication, and life experiences.

▲ The impact of beliefs and past experiences on negotiation and leadership styles.

- ▲ The characteristics and utility of different leadership styles.

- ▲ Sources of personal reward and rejuvenation and signs of stress and fatigue.

SKILLS

Basic. Through participation in this program, a participant will:

1. Recognize that personal attitudes, beliefs, and experiences (successes and failures) influence one's leadership style.

Advanced. With more experience and building on the basic skills, MCH leaders will:

2. Use self-reflection techniques effectively to enhance program development, scholarship and interpersonal relationships.

3. Identify a framework for productive feedback from peers and mentors.

MCH Leadership Competency 3: Ethics and Professionalism

DEFINITION

Ethical behavior and professionalism include conduct congruent with generally accepted moral principles and values and with professional guidelines based on those principles and values.

This definition includes general leadership ethics, such as honesty and responsibility, as well as ethics specific to the MCH population, such as reducing health disparities and behaving in a culturally competent manner.

KNOWLEDGE AREAS

Through participation in this program, a participant will know:

- ▲ The principles, values, and ethical behaviors such as beneficence, nonmaleficence, truthfulness, justice, and respect for autonomy that underlie professional conduct with in the health care system.

- ▲ Ethical and legal principles of public health and clinical practice.

- ▲ His or her professional association's code of ethics.

- ▲ Institutional review board processes and criteria for ensuring ethical study design and informed consent as they relate to human subjects research and translation of research to practice.

SKILLS

Basic. Through participation in this program, a participant will:

1. Identify and address ethical issues in patient care, human subjects research, and public health theory and practice.

2. Describe the ethical implications of health disparities within MCH populations.

3. Interact with others and solve problems in an ethical manner.

Advanced. With more experience and building on the basic skills, MCH leaders will:

4. Identify ethical dilemmas and issues that affect MCH population groups and initiate and act as catalyst for the discussion of these dilemmas and issues.

5. Consider the culture and values of communities in the development of polices, programs, and practices that may affect them.

6. Describe the ethical implications of health disparities within MCH populations and propose strategies to address them.

MCH Leadership Competency 4: Critical Thinking

DEFINITION

Critical thinking is the ability to identify an issue, dilemma, or problem; frame it as a specific question; explore and evaluate information relevant to the question; and integrate the information into development of a resolution. An advanced manifestation of critical thinking is evidence-based practice – the conscientious, explicit, and judicious use of current best evidence about practice, the creation of policy, and the conduct of research.

KNOWLEDGE AREAS

Through participation in this program, a participant will know:

▲ The cognitive hierarchy of critical thinking: knowledge, comprehension, application, analysis, syntheses, and evaluation.

▲ Basic statistics and epidemiology, qualitative and quantitative research, systematic reviews, and meta-analyses.

▲ The levels of evidence used in the guidelines of the U.S. Preventive Health Services Task Force.

Basic. Through participation in this program, a participant will:

1. Use population data to assist in determining the needs of a population for the purposes of designing programs, formulating policy, and conducting research or training.

2. Formulate a focused and important practice, research or policy question.

Advanced. With more experience and building on the basic skills, MCH leaders will:

3. Apply important evidence-based practice guidelines and policies in their field.

4. Identify practices and policies that are not evidence-based but are of sufficient promise that they can be used in situations where actions are needed.

5. Translate research findings to meet the needs of different audiences.

6. Discuss various strategies, including supportive evidence, for the implementation of a policy.

II. Others

MCH Leadership Competency 5: Communication

DEFINITION

Communication is the verbal, nonverbal, and written sharing of information. The communication process consists of a sender who encodes and presents the message and the receiver(s) who receives and decodes the message. Communication involves both the message (what is being said) and the delivery method (how the message is presented).

Skillful communication is the ability to convey information to and receive information from others effectively and is a foundation of MCH practice, policy, and research. It includes the essential components of attentive listening and clarity in writing or speaking. An understanding of the impact of culture and disability on communication between MCH professionals and the individuals, families, and populations that they serve is also important.

KNOWLEDGE AREAS

Through participation in this program, a participant will know:

▲ Principles of communication for all three communication modalities – verbal, written, and nonverbal.

- ▲ Challenges to communication, such as contextual mediators, literacy levels, cultural meanings, professional terms, and acronyms; and approaches to overcome those challenges.

- ▲ The MCH vocabulary (for example, acronyms and terms specific to the MCH field) to express and understand information.

SKILLS

Basic. Through participation in this program, a participant will:

1. Share thoughts, ideas, and feelings effectively in discussions, meetings, and presentations with diverse individuals and groups.

2. Write clearly and effectively to express information about issues and services that affect MCH population groups.

3. Understand nonverbal communication cues in self and others.

4. Listen attentively and actively.

5. Tailor information for the intended audience(s) (consumers, policymakers, clinical, public, etc.) by using appropriate communication modalities (verbal, written, nonverbal).

Advanced. With more experience and building on the basic skills, MCH leaders will:

6. Demonstrate the ability to communicate clearly through effective presentations and written scholarship about MCH populations, issues, and/or services.

7. Articulate a shared vision for improved health status of MCH populations.

8. Employ a repertoire of communication skills that includes disseminating information in a crisis, explaining health risks, and relaying difficult news.

9. Refine active listening skills to understand and evaluate the information shared by others.

10. Craft a convincing MCH story designed to motivate constituents and policymakers to take action.

MCH Leadership Competency 6: Negotiation and Conflict Resolution

DEFINITIONS

Negotiation is a cooperative process whereby participants try to find a solution that meets the legitimate interests of involved parties; it is a discussion intended to produce an agreement.

Conflict resolution is the process of (1) resolving or managing a dispute by sharing each side's needs and (2) adequately addressing their interests so that they are satisfied with the outcome.[12]

An MCH professional approaches the negotiation setting with objectivity, open to new information but aware of long-term desired outcomes that include relationship-building and development of trust. He or she recognizes when compromise is appropriate to overcome an impasse and when persistence toward a different solution is warranted.

KNOWLEDGE

Through participation in this program, a participant will know:

▲ Characteristics of conflict and how conflict is manifested in organizational contexts.

▲ Sources of potential conflict in an interdisciplinary setting. These could include the differences in terminology and cultures among disciplines and the relationships between mentors and students.

▲ The theories pertaining to conflict management and negotiation among groups with conflicting interests.

▲ The strategies and techniques useful in successful negotiation.

SKILLS

Basic. Through participation in this program, a participant will:

1. Apply strategies and techniques of effective negotiation and evaluate the impact of personal communication and negotiation style on outcomes.

Advanced. With more experience and building on the basic skills, MCH leaders will:

2. Demonstrate the ability to manage conflict in a constructive manner.

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[12] Wikipedia. *Conflict resolution definition.* Retrieved February 1, 2007, from http://en.wikipedia.org/wiki/Conflict_resolution

MCH Leadership Competency 7: Cultural Competency

DEFINITION

Cultural competence is the knowledge, interpersonal skills, and behaviors that enable a system, organization, program, or individual to work effectively cross-culturally by understanding, appreciating, honoring, and respecting cultural differences and similarities within and between cultures. The acquisition of cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

MCH professionals exhibit cultural competence through their interpersonal interactions and through the design of interventions, programs, and research studies that recognize and address cultural differences. (Adapted from National Center for Cultural Competence, Cultural Competence: Definition and Conceptual Framework, http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html)

KNOWLEDGE AREAS

Through participation in this program, a participant will know:

▲ The influence of personal biases and assumptions on individual and organizational behavior.

▲ How cultural, ethnic, and socioeconomic factors influence the access to health care services.

▲ The impact of culturally competent health care practices on individuals' access to health services, participation in health promotion and prevention programs, adherence to treatment plans, and overall health outcomes.

SKILLS

Basic. Through participation in this program, a participant will:

1. Conduct personal and organizational self-assessments regarding cultural competence.

2. Assess strengths of individuals and communities and respond appropriately to their needs based on sensitivity to and respect for their diverse cultural and ethnic backgrounds and socioeconomic status.

3. Suggest modifications of health services to meet the specific needs of a group or family, community, and/or population.

Advanced. With more experience and building on the basic skills, MCH leaders will:

4. Employ strategies to assure culturally-sensitive public health and health service delivery systems.

5. Integrate cultural competency into programs, research, scholarship, and policies.

MCH Leadership Competency 8: Family-centered Care

DEFINITION

Family-centered care ensures the health and well-being of children and their families though a respectful family-professional partnership that includes shared decisionmaking. It honors the strengths, cultures, traditions, and expertise that everyone brings to this relationship.[13]

Historically, in the field of MCH, the concept of family-centered care was developed within the community of parents, advocates and health professionals concerned for children with special health care needs (CSHCN).[14]

KNOWLEDGE

Through participation in this program, a participant will know:

▲ The definition of family-centered care and the origin of the family-centered care perspective.

▲ At least one example of the principles of family-centered care in MCH policies, programs, or clinical practice (e.g., a medical home model of primary care).[15]

SKILLS

Basic. Through participation in this program, a participant will:

1. Solicit and use family input in a meaningful way in the design or delivery of clinical services, program planning and evaluation.

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[13] This definition comes from the MCHB Family-Centered Curricula Workgroup, January 2007.

[14] CSHCN are individuals who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. This group includes infants and children from birth to age 21 with special health care needs whom the State has elected to provide with services funded through Title V.
Source: Health Resources and Services Administration (HRSA). *Title V Information System glossary.* Retrieved January 10, 2007, from HRSA Web site: https://perfdata.hrsa.gov/MCHB/MCHReports/Glossary.html

[15] A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.
Source: American Academy of Pediatrics (AAP). Retrieved January 10, 2007, from AAP Web site: www.aap.org

2. Operationalize the "family-centered care" philosophical constructs (e.g., families and professionals share decisionmaking; professionals use a strengths-based approach when working with families) and use these constructs to critique and strengthen practices, programs, or policies that affect MCH population groups.

Advanced. With more experience and building on the basic skills, MCH leaders will:

3. Ensure that family perspectives play a pivotal role in MCH research, clinical practice, programs, or policy (e.g., in community needs assessments, processes to establish priorities for new initiatives or research agendas, or the development of clinical guidelines).

4. Assist primary care providers, organizations, and/or health plans to develop, implement, and/or evaluate models of family-centered care.

5. Incorporate family-centered and medical home models of health care delivery into health professions and continuing education curricula and assess the effect of this training on professional skills, health programs, or policies.

MCH Leadership Competency 9: Developing Others Through Teaching and Mentoring

DEFINITION

Communication, critical thinking, and professionalism competencies are critical to teaching and mentoring. Teaching involves designing the learning environment (includes developing learning objectives and curricula), providing resources to facilitate learning, modeling the process of effective learning in the subject matter, and evaluating whether learning occurred.

In contrast, mentoring is influencing the career development and career satisfaction of a colleague by acting as an advocate, coach, teacher, guide, role model, benevolent authority, door opener, resource, cheerful critic, and career enthusiast.

KNOWLEDGE

Through participation in this program, a participant will know:

▲ A variety of teaching strategies appropriate to the goals and context of the session.

▲ Principles of adult learning.

▲ Characteristics of a positive mentoring relationship, including confidentiality, mutuality of purpose, and trust.

▲ Responsibilities of both parties in the mentor-protégé relationship.

Basic. Through participation in this program, a participant will:

1. Recognize and create learning opportunities for others.

2. Participate in a mutually beneficial mentoring relationship.

Advanced. With more experience and building on the basic skills, MCH leaders will:

3. Teach audiences of different sizes, backgrounds, and settings.

4. Incorporate feedback from learners to evaluate teaching effectiveness.

5. Give and receive constructive feedback about behaviors and performance.

MCH Leadership Competency 10: Interdisciplinary Team Building

DEFINITION

MCH systems are interdisciplinary in nature. Interdisciplinary practice provides a supportive environment in which the skills and expertise of team members from different disciplines, including families, are seen as essential and synergistic. The expertise of each team member is elicited and valued in making joint outcome-driven decisions to benefit individuals or groups and to solve community or systems problems.

The "team," which is the core of interdisciplinary practice, is characterized by mutual respect among disciplines and stakeholders, a sharing of leadership, investment in the team process, and acceptance of responsibility and accountability for outcomes. Members of an interdisciplinary team may include a variety of professionals, consumers, families, and community partners.

KNOWLEDGE AREAS

Through participation in this program, a participant will know:

▲ Team building concepts:

 ▪ Stages of team development

 ▪ Practices that enhance teamwork

 ▪ Managing team dynamics.

▲ Various approaches to practice (evolution from multidisciplinary to interdisciplinary to transdisciplinary practice).

▲ The roles and competencies of individual disciplines.

SKILLS

Basic. Through participation in this program, a participant will:

1. Identify and assemble team members appropriate to a given task (e.g., research question, program, curriculum, clinical care issue).

2. Develop and articulate shared vision, roles and responsibilities.

3. Facilitate group processes for team-based decisions (e.g., foster collaboration and cooperation).

4. Value and honor diverse perspectives (e.g., discipline, ethnic, cultural, economic) of team members.

Advanced. With more experience and building on the basic skills, MCH leaders will:

5. Identify forces that influence team dynamics.

6. Enhance team functioning, redirect team dynamics, and achieve a shared vision.

7. Share leadership based on appropriate use of team member strengths in accomplishing activities and managing challenges for the team.

8. Use knowledge of disciplinary competencies and roles to improve teaching, research, advocacy, and systems of care.

9. Use shared outcomes to promote team synergy.

III. Wider Community

MCH Leadership Competency 11: Working with Communities and Systems

DEFINITIONS

Improving the health status of MCH population groups is a complex process because so many factors influence the health of children, adolescents, and families. Therefore, solving health problems and improving health status requires the active involvement of many disciplines and an array of public- and private-sector jurisdictions. Reaching a goal of promoting health and preventing problems requires a broad-based systems approach, rather than a categorical approach, to the issues.

Systems thinking is the ability to appreciate complexity. This includes the ability to see the whole and the parts to understand the ways in which the parts interact and influence outcomes.

Collaboration is a mutually beneficial and well-defined relationship entered by two or more organizations to achieve goals and act as one to solve an agreed upon issue. Key to collaboration is the use of supportive and inclusive methods to ensure that those represented by the collaboration are included in the change process and share power. (Source: web.tc.Columbia.edu/families/TWC)

Constituency building depends on the core competencies of communication, self- reflection, critical thinking, and ethics and professionalism.

The successful MCH leader thinks systemically about the complexity of policy, practice, and research challenges. Personality characteristics and temperament that may aid in this competency include passion, persistence, self-motivation, optimism, flexibility, creativity, charisma, humility, and patience.

KNOWLEDGE
Through participation in this program, a participant will know:

▲ Basic features and issues of health care systems and health economics.

▲ Relationships between the mission, vision, and goals of an organization to its strategic planning, operations, and the community to which it belongs.

▲ Basic business and administrative principles related to planning, funding, budgeting, staffing, managing, evaluating, and representing health care systems and organizations.

▲ Principles of building constituencies and collaborations in communities and among organizations.

▲ Principles of systems-thinking that describe the hierarchy of systems.

SKILLS
Basic. Through participation in this program, a participant will:

1. Participate in basic strategic planning processes such as developing a mission, vision, strategic goals, and activities.

2. Develop agendas and lead meetings effectively.

3. Identify community stakeholders and their extent of engagement in the collaboration process.

4. Interpret situations systemically; i.e., identifying both the whole situation and the dynamic interplay among its parts.

Advanced. With more experience and building on the basic skills, MCH leaders will:

5. Assess the environment to determine goals and objectives for a new or continuing program, list factors that facilitate or impede implementation, develop priorities, and establish a timeline for implementation.

6. Manage a project effectively and efficiently including planning, implementing, delegating and sharing responsibility, staffing, and evaluation.

7. Translate mission and vision statements for different audiences, understanding their different cultures, perspectives, and use of language.

8. Use negotiation and conflict resolution strategies with stakeholders when appropriate.

9. Maintain a strong stakeholder group with broad based involvement in an environment of trust and use an open process.

MCH Leadership Competency 12: Policy and Advocacy

DEFINITIONS

A policy is a decision designed to address a given problem or interrelated set of problems that affect a large number of people. Advocacy consists of activities carried out on behalf of policies or constituencies; its purpose is to influence outcomes that affect peoples' lives.

It is important for MCH leaders to possess policy and advocacy skills, because they often must defend and advocate for MCH resources in competitive economic and political environments.

KNOWLEDGE AREAS

Through participation in this program, a participant will know:

▲ Public policy process at local, State, and national levels.

▲ Current public-sector policies and private-sector initiatives that affect MCH population groups.

▲ Appropriate methods for informing and educating policymakers about the needs of and impacts of current policies on MCH population groups.

Basic. Through participation in this program, a participant will:

1. Frame problems based on key data, including economic, political, and social trends that affect the MCH population.

2. Use data, levels of evidence, and evaluative criteria in proposing policy change.

3. Identify a wide range of stakeholders who influence changes in MCH policy.

Advanced. With more experience and building on the basic skills, MCH leaders will:

4. Apply appropriate evaluative criteria to the analysis of alternative policies.

5. Analyze the potential impact of policies on diverse population groups.

6. Understand the roles and relationships of groups involved in the public policy development and implementation process, including the executive, legislative, and judicial branches of government at all levels and interest groups.

7. Formulate strategies to balance the interests of diverse stakeholders, consistent with desired policy change.

8. Present evidence and information to a legislative body, key decisionmakers, foundations, or the general public.

Appendix A:

Time Line of Development of MCH Leadership Competencies

Date	Activity	Result
1987–1988	MCHB convenes a Leadership Training Conference of MCHB funded training grants.	Leadership Training Conference Report. Chapel Hill, NC: University of North Carolina at Chapel Hill. http://www.mchb.hrsa.gov/training/documents/ MCH_LeadershipTraining.pdf
1993, revised in 2001	The Association of Teachers of Maternal and Child Health develops MCH Competencies.	http://www.atmch.org/TeachingTools/mchcomps.pdf
2000s	Pediatric Pulmonary Centers assess the leadership outcomes of their trainees.	McDougal, JA. Lapidus, J. Albanese, M. and Redding, G. "Interdisciplinary Leadership Training Outcomes of Maternal and Child Health-Funded Pediatric Pulmonary Centers", Maternal and Child Health Journal, Vol. 7, No. 4, December 2003 http://ppc.mchtraining.net/index.php?option=com_docman&task=cat_view&gid=43&Itemid=52
2000	MCHB commissions an evaluation of the MCH Training Program, which includes a literature review, a record review, focus groups, site visits, and a survey of former MCH leadership trainees.	http://www.mchb.hrsa.gov/training/resources.asp
2000s	In partnership with MCH leadership training grantees, MCHB's Training Program develops a national leadership performance measure.	Based on MCHB's leadership training performance measure, leadership may be exerted in one or more of the following four areas, each of which requires quite different knowledge and skills: ▸ Academics: e.g., faculty member teaching-mentoring in MCH-related field, conducting MCH-related research, providing consultation or technical assistance in MCH, publishing and presenting in key MCH areas, success in procuring grant and other funding in MCH ▸ Clinical Practice: e.g., development of guidelines for specific MCH conditions; participation as officer or chairperson of committees on State, National, or local clinical organizations, task forces, community boards, etc.; clinical preceptor for MCH trainees; research, publication, and key presentations on MCH clinical issues; serves in a clinical leadership position as director, team leader, chairperson, etc. ▸ Public Health/Public Policy: e.g., leadership position in local, State, or National public organizations or government entity; conducts strategic planning; participates in program evaluation and public policy development; success in procuring grant and other funding; influencing MCH legislation; publication or presentations in key MCH issues. ▸ Advocacy: e.g., through efforts at the community, State, regional, and national levels influencing positive change in MCH through creative promotion, support, and activities – both private and public (for example, developing a citywide SIDS awareness and prevention program through community churches)

Date	Activity	Result
2003	MCHB commissions an analysis from the Center for Educational Outcomes (CEdO) to examine how MCH Training Programs define leadership and how they determine when they have been successful in producing leaders. CEdO's analysis includes a literature review, an analysis of the leadership narratives from interdisciplinary MCH Training Program 2003 progress reports, and focus groups with many training programs.	*Assessment in MCH Training Programs: Working Towards Data-driven Standards of Excellence in Leadership Education*
2004	The University of Washington and MCHB sponsor the MCH Working Conference: The Future of Maternal and Child Health Leadership Training, Seattle, Washington.	C Huebner and W Mouradian. 2004. *Draft Report from the MCH Working Conference: The Future of Maternal and Child Health Leadership Training*, April 19–21, 2004. Seattle: University of Washington.
Late 2000s	Vermont-ILEHP develops a leadership assessment tool, Assessment of Professional Leadership Abilities Assessment Scale	http://www.aucd.org/aucd_lend.htm
Late 2000s	Development of draft MCH Leadership Competencies	http://leadership.mchtraining.net/
2007	Article describing the 2004 Future of MCH Leadership Training conference published in the MCH Journal, "Future Directions in Leadership Training of MCH Professionals: Cross-Cutting MCH Leadership Competencies."	http://dx.doi.org/10.1007/s10995-006-0170-3
2008-2009	Modified Delphi Process conducted	Release of Version 3.0 of the MCH Leadership Competencies

Appendix B:

MCH Pyramid

MCHB uses the construct of a pyramid to describe the four levels of core public health services for the MCH population. Starting at the base, these are (1) infrastructure-building services, (2) population-based services, (3) enabling services, and (4) direct health care (gap-filling) services. Infrastructure-building and population-based services provide the broad foundation upon which enabling and direct care services rest (Figure A-1). The MCH health services pyramid provides a useful framework for understanding programmatic directions and resource allocation by the Bureau and its partners as they collaborate to carry out the MCHB mission and accomplish the MCHB goals.

MCH leaders work at all four levels of the pyramid. Leaders emerge within each of these four levels and can move between levels as their careers progress.
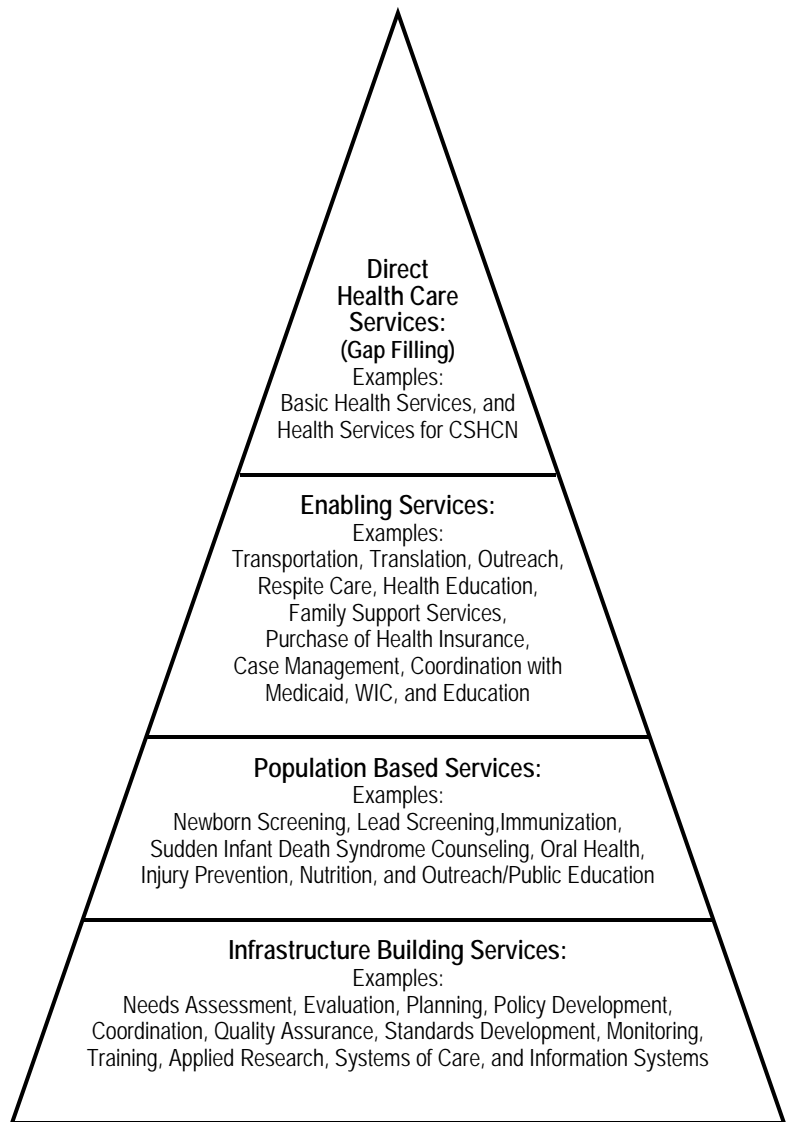

Direct Health Care Services:
(Gap Filling)
Examples:
Basic Health Services, and
Health Services for CSHCN

Enabling Services:
Examples:
Transportation, Translation, Outreach,
Respite Care, Health Education,
Family Support Services,
Purchase of Health Insurance,
Case Management, Coordination with
Medicaid, WIC, and Education

Population Based Services:
Examples:
Newborn Screening, Lead Screening,Immunization,
Sudden Infant Death Syndrome Counseling, Oral Health,
Injury Prevention, Nutrition, and Outreach/Public Education

Infrastructure Building Services:
Examples:
Needs Assessment, Evaluation, Planning, Policy Development,
Coordination, Quality Assurance, Standards Development, Monitoring,
Training, Applied Research, Systems of Care, and Information Systems

Figure A-1. Core Public Health Services Delivered by MCH Agencies

Appendix C:

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