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Programs and Participants at the Outset

A Brief on Four Primary Care Leadership Development Programs Funded by the Colorado Health Foundation

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Table of Contents

I. OVERVIEW

Our goal is to understand how we can support the development of primary care clinicians' leadership and advocacy for health care improvement by learning from the experiences of four programs recently funded by the Colorado Health Foundation (CHF). To begin, we must understand the programs and their participants.

The purpose of this brief is to acquaint the reader with the four CHF-funded primary care leadership development programs, their initial recruitment and selection processes, and their participants at the outset of the programs. In part II, we summarize the observed patterns across the four programs. In part III, we discuss each program individually in detail, compiling the specific data underlying the aforementioned patterns. In parts IV and V, we conclude with a series of hypotheses and ideas that warrant further exploration and a brief summary. The appendix includes information on the study and its methods. Future briefs will discuss the four programs' implementation processes and potential outcomes.

Context for this Brief

The Colorado Health Foundation (CHF) has embarked on an important effort to support the development of primary care clinician champions who lead and advocate for comprehensive, person-centered care at the practice, community, state, or federal level. The ultimate goal of this initiative is to enhance the primary care workforce to drive change, strengthen the delivery of services, and improve the health outcomes of those served.

In 2017 and 2018, CHF awarded grants to four organizations--the Colorado Community Health Network (CCHN), John Snow Inc. (JSI), Center for Creative Leadership (CCL), and the Regional Institute for Health and Environmental Leadership (RIHEL)—to conduct primary care leadership development programs. Although each of the grantees refer to their programs by particular names, we will use the organizational acronyms throughout our report to reduce confusion and need for remembering program names and acronyms (e.g., EHA, EL, RCPCL, PCMAC).

This evaluation is intended to document the work that has been supported by four grants from CHF and learn lessons that can inform future primary care leadership development efforts. Our last brief (Taylor & Joftus, 2017) outlined a framework for leadership and advocacy. This and subsequent briefs will draw on that initial framework to examine the four grantees' programs, beginning here by describing the programs and their participants at the outset of their work.

II. PATTERNS AND SUMMARY ACROSS THE LEADERSHIP DEVELOPMENT PROGRAMS

Although each of the four programs and their participants are unique, we begin by trying to summarize program objectives, components, foci, recruitment and selection processes, and participants.

Method

In this brief, we base our descriptions of the programs on their grant applications, a review of their curriculum materials, and emails and interviews with their developers, as of the summer of 2018. Our discussion of recruitment and selection processes is informed by reviewing participant applications, participant application data, and interviews with developers. We base our descriptions of the programs' participants on both data collected on participants' applications as well as a pre-program baseline survey administered before the programs began. Programs and participants change to some extent during implementation (e.g., developers decide to add a training or change topics, a participant decides to drop out) so the current state of the programs and participant cohorts may differ from what we understood as of the summer of 2018. These changes during implementation will be discussed in our future briefs. Additional detail is available in the appendix.

Program Objectives

The four programs shared many of the same objectives for what their participants would develop through their program. Table 1 maps the objectives each program stated in their initial grant application and materials. Two or more of the programs typically mentioned each objective, sometimes using somewhat different terminology. Although some programs have blank cells indicating that they did not explicitly mention an objective (e.g., CCL and objectives of confidence, commitment, and optimism) in their initial grant applications, ongoing observations of the programs have generally suggested that all programs are addressing these knowledge, skill, and motivational objectives either explicitly in later curricular materials or at least implicitly in their work. The main exception is that JSI by design does not have advocacy and policy objectives.

Table 1. Summary of Program Objectives by Program

Objective	CCHN	JSI	CCL	RIHEL
Knowledge				
Knowledge of self	Knowledge of self	Knowledge of self	Individual leadership capacity	Self knowledge
Knowledge of best practice	Knowledge of best practice	Demonstrate and describe the quadruple aim	Understand best practice for reform, integration and transformation	Knowledge of best practices for reform, integration and transformation
Knowledge of policy	Knowledge of the policy issues of the day		Understand policy	
Skill				
Strategic thinking	Strategic thinking		Strategic thinking	
Managing and managing sensitive issues and conflict	Managing	Dealing with sensitive controversial issues	Leading others	
Collaboration	Collaboration	Collaboration, team based care	Collaboration and teaming	Willingness to collaborate
Communication	Communication	Communication, Persuasion	Communication	Effective communication
Vision		Vision		
Engaging executives		Working with board and execs and staff		Getting administration on board
Advocacy	Advocacy		Advocate	Advocacy actions
Networking	Networking		Peer learning network	
Technical work		Technical		
Motivation				
Confidence	Confidence	Confidence		Confidence, willingness to lead
Commitment	Commitment	Passion and commitment		
Optimism	Optimism (hope)			Optimism

Working conditions	Satisfaction, support, ability to grow	Uncertain and vague situations	Resilience	
Identity as a leader and advocate				

Source: Review of program grant applications

Program Foci

The programs are designed to be fairly comprehensive in their approach to leadership development. All four programs cover a range of arenas of leadership, from the personal to leadership in a larger system or network. All programs begin by delving into the personal arena of leadership, using various personality, emotional intelligence, and 360 degree leadership assessments as well as considerable reflection and coaching time to understand and work on participants' individual leadership behavior. All programs also engage their participants in actual events in their local clinical practice and organization. The programs appear to focus less attention on leading across their larger health system and its executives, and it is in their focus on the broader arenas of leadership: network building and influencing the larger field that the programs appear to differ. Beyond building strong ties among their cohort members, it is as yet unclear the extent to which each program attempts to build participants' skills in building and influencing their professional networks. While CCHN, CCL, and RIHEL all explicitly focus on advocacy and health care policy, JSI does not.

The programs focus on the inspirational or early phase of leader development. That is, the programs intend to inspire individuals to become leaders and advocates or to activate and expand their nascent leadership. The programs only touch on the implementation phase of leadership through the experiential capstone projects and any optional attempts at leading change that the participants decide to pursue during the program. The programs do have some participants who have been leading for several years and may be in the sustaining phase of leadership, but they do not design the programs expressly for these individuals nor spend a great deal of time discussing how to sustain leadership or plan leadership succession.

Program Components

Overall, all four programs were designed to be intensive, multi-component training experiences including a substantial number of contact hours (approximately 50-80) and extending across 10-16 months.

The programs typically use a mix of assessments, in-person, virtual/webinar, and coaching sessions along with a major project to deliver their training. Each program places a little more

weight on different components. For instance, CCL relies heavily on the extended two-day in-person trainings but also calls for a relatively large number of intersession assignments; CCHN and RIHEL place a greater emphasis on a combination of in-person time and on coaching; and JSI uses a greater number of virtual/webinar sessions.

Table 2 presents the main activities used by each program as we currently understand them. We continue to collect information about the events used by each program and it should be noted that the developers adjust programs occasionally as they progress to adapt to the participants needs.

Table 2. Main Program Components by Program

Component	CCHN	JSI	CCL	RIHEL
Assessments	Yes, DISC EQ2.0		Yes, Benchmarks by Design	Yes, EQI LPI 360
In-person trainings	5 one-day workshops including a day at the Capitol	2 sessions plus the TBC Learning Forum (another day later added)	3 two-day sessions	4 one-and-a half-day sessions
Webinars	7 webinars	5 virtual meetings and 4 content webinars	One	
Coaching	6 sessions	Mentoring that appears to be infrequent (at option of participant)	5 sessions of coaching	Continuous throughout
Assignments		Inter-disciplinary virtual team meetings	7 monthly intersession assignments and Peer group meetings	Intentional actions including: Policy brief, elevator pitch, meeting with policy maker
Projects	Capstone project, celebration	Project, presentation at conference, (options were later broadened) celebration	Key Leadership Challenge	Capstone project

Source: Review of program curricula and documents

Developers have stressed their efforts to individualize training for each participant. Typically, developers individualize through executive coaching by the main trainers, peer coaching from program alumni or volunteers, or mentoring. As one of the program developers stated,

"Coaching is the secret ingredient. It provides something for everyone, each participant gets their own tailored coaching and takes what you learn, the insights, in other trainings and is customized action just for you, holding you accountable for trying to apply them in your work. It's like the fertilizer, the glue, to mix a few metaphors." The other component that enabled individualization of the training was the capstone project, the topic for which each individual participant selected.

Developers also have stressed the need to make the training ongoing across the approximately year-long program. The coaching component was again seen as critical to extend participants' effort and learning across the periods between the major in-person or virtual gatherings of the full cohorts. The capstone project was also seen to be a means to promote steady effort and learning across the periods when no other events are scheduled. Meetings with small groups of others in the cohort interested in a similar topic or project were also used in some cases. Assignments to complete during the gaps of the training were also used to attempt to make the learning more ongoing.

Lastly, developers were concerned with how to transfer the learnings during trainings into the participants' daily practice. The capstone project is seen as a way to do this, and coaching could potentially support transfer, as well as routine encouragements to take what they learned back and try it in their clinic or workplace. However, this concern appears to persist.

Recruitment and Selection

The four programs collectively recruited 133 difficult-to-recruit primary care providers from a range of locales and positions. **The programs nearly reached their intended quotas:**

- CCHN's cohort (16 participants) was planned to be the smallest of the programs but was even smaller than expected
- JSI (23 participants) lost a few recruits through early attrition but replaced them
- CCL extended their window to reach their ambitious intended target (50 participants)
- RIHEL just missed their ambitious intended target (44 participants).

The programs approached recruitment and selection of participants as an operational task rather than a strategic opportunity. Recruitment was a primary concern for all the programs. There were concerns expressed about whether the intended participants had the time available, could be released from clinic and other key responsibilities, and whether the stipends would be enough. From our vantage point, the programs viewed recruitment and selection primarily as a chore to accomplish, a quota to fill, a challenging hurdle to clear, rather than as a chance to attract and select the individuals who would benefit the most from their program. We asked several times in early phone calls and emails about their strategies around recruitment and selection and the program staff responded about finding ways to get the right numbers and the

right mix of participant roles to fill the cohort and ensure all met eligibility and basic appropriateness requirements, but they did not raise the idea of how to generate a large excess pool and then use selection/rejection to determine a set of participants that would maximize the impact of their work. We asked developers in follow-up interviews after recruitment and selection about these tasks, and they said that they did reject some applications (never more than 10-15%) due to ineligibility or because the applicants exhibited too little effort or investment in answering the application questions but not because they were selecting for greatest impact.

Desired cohorts contained a mix of participant roles. This appeared to be a central constraint in the developers' heads as recruiting progressed. As one program grant application stated, their goal was "to achieve a diverse cohort, representative of many types of practices, organizations, and geographic areas."

The programs provided fairly long windows for applications to be submitted and most extended their deadlines and some delayed their training start dates in order to meet their intended targets. In general, programs required a two- to three-month application window to attain their intended recruitment targets. The JSI application process was somewhat unique in that it was an extension of the existing TBC program and used nominators to submit applications rather than the applicants themselves.

The application process was streamlined and did not appear to be a barrier to participation. The applications were not burdensome, taking roughly 10 to 30 minutes to complete and containing between 7 and 22 questions. The majority of questions were of a forced choice or very brief fill-in-the-blank format. There were between 2 (JSI) and 8 (RIHEL) longer fill-in-the-blank format questions and those were typically answered in one to three paragraphs and rarely more than 200-300 words. For example, one of the more involved application questions that generated the longest responses was the following: *Tell the story (share reflections) of your personal developmental journey as a leader. Describe one specific experience that influenced your current perspective on leadership. (RIHEL).* There are many remarkable and often inspiring stories in the applications to these programs, showing the remarkable people who have been drawn to these programs. Typically, the core team of program developers, trainers, and managers reviewed the applications as a group and made selections.

Programs noted a few strategies that seemed to them to be effective during recruitment. Strategies included utilizing their organizations' close relationships with Health Centers, or other organizations in their partner networks; reaching out to providers who have participated in their previous training offerings; and locating providers who were part of the Colorado Health Service Corps loan repayment program. The programs typically offered a couple slots to each of their partner organizations and disseminated the call for applicants through their networks of alumni from past training programs. The programs then took the nominated personnel and referred

applicants, only rejecting applicants who were outside the eligibility guidelines. Essentially, this strategy served to "farm out" or delegate the responsibility of recruitment. Of course, the clinics, systems, and partner organizations have greater familiarity with the pool of potential candidates, but they lack the strategic perspective that would maximize impact. It appears that the partners often made some effort to nominate candidates who would do the best in the program or who would benefit from the program. However, there are occasions where the participants selected by partner organizations had already participated in a similar training, enjoyed attending trainings, or was receiving a perk for retention purposes.

The overall pool is unknown to us. It may be that there are few individuals in the partner organizations who fit the eligibility guidelines. It may be that the participants selected are the best to maximize the program's impact. But this is hard to imagine, given the evidence we have before us.

Program developers also noted various obstacles to recruitment, including CCHN's note that uncertainty in federal funding during their recruitment window caused hesitation by partners and therefore delays to RIHEL's constraint of avoiding rural areas. In the end, no program had to turn away many applicants; the acceptance rate for the programs was approximately 90%.

We are left with the impression that recruitment and selection, although critical early hurdles successfully cleared by the programs, were missed opportunities for maximizing the impact of the programs. Imagine a scenario where programs were well known as prized credentials across Colorado, and there was a pool of applicants that allowed programs to accept and select only 50% from the pool. Presumably, they would have engaged in an internal discussion about how to choose from among their many applicants. They would have had multiple individuals in each role, geographic area, and health system, so these would not have been such strong constraints and the developers would have had to determine a logic for why they would select one qualified, requirement-satisfying applicant over another.

There are issues with selection of course. We do not want the programs to select for pre-existing exceptional and active leaders who don't need the training or have already experienced extremely similar training. We want to select participants who will grow the most in their leadership from experiencing the training.

None of this is to say that the selected participants were not a good group to work with or that they won't benefit from the training or that the programs won't have considerable impact; those are empirical questions awaiting answers. What we are saying is that, given the constraints and the recruitment and selection processes used, it is hard to imagine that the current participants are the *optimal* group for these programs to achieve their maximum impact.

Participants

To understand the programs, we must also understand the population of participants who they serve. Table 2 summarizes many of the measured characteristics of program cohorts before the program began and shows the cohorts of the four programs side-by-side. This table greatly reduces the data presented in the individual program sections below and in so doing necessarily trades-off detail and precision to reveal and summarize general patterns. We encourage the reader to refer to the separate sections for each program to understand the detailed characteristics of each unique cohort. Although we bold certain cells to highlight where certain program cohorts appear to stand out, we add a note of caution against making strict technical program cohort vs. program cohort comparisons. Although the questions were by-and-large the same on each pre-program survey, in some cases programs had their own wording of a question, asked questions in different orders or formats, or did not ask a question because it was less relevant to their program or its goals (e.g., JSI and advocacy). With those caveats, the general patterns of participant characteristics before the program began (shown in table 2) are as follows:

- CCHN had the smallest cohort and CCL had the largest number of participants.
- JSI had the least senior cohort in terms of their position, CCL had the most senior participants and RIHEL had the most participants from complementary areas such as pharmacy, psychology, mental health, behavioral health and dental health.
- Each program had a different geographic focus, but demographically the cohorts were largely female and Caucasian and in the middle of their careers.
- Almost all participants said that they were already providing leadership in their organization but few had been recently trained or mentored in leadership.
- CCL participants (the most senior in position) self-identified the most as leaders.
- Most participants applied for the program and expected to gain leadership skills from the programs, but as many as a quarter in some programs were vague about why they applied. A fair number of CCHN participants said they expected to gain advocacy skills, several CCL participants expected to build networks, and several RIHEL participants expected to build confidence.
- Participants from all of the programs entered feeling on average very satisfied, supported and able to grow in their current job, very committed, and very optimistic.
- They felt most knowledgeable about their own strengths and weakness, next most knowledgeable about policy, and least knowledgeable about best practices in primary care.
- Their confidence was highest among leadership competencies and lowest in the area of advocacy. RIHEL participants had the highest level of agreement that they had a strong network and JSI participants had the lowest at the outset of the program.

Table 3. Summary of Cohort Characteristics by Program

Cohort characteristic before beginning of program	CCHN	JSI	CCL	RIHEL
Size	**16**	23	**50 in 2 cohorts**	44
Position and Mix of professional background	Senior in position	**Most junior in position** No complementary professions	**Most senior in position**	Senior in position **Most diverse set including pharma, psych, mental, behavioral, dental health**
Geographic location	All in SE Colorado and **rural**	Diverse locations dependent on existing TBC program	**Rural**	**Urban and Suburban**
Demographics	2/3 Female, 2/3 Caucasian, most 5-10 years experience with their organization	9/10 Female, most Caucasian but 4/10 Hispanic, early or mid career	Approx. ½ Female, 2/3 Caucasian	¾ Female, ¾ Caucasian, most mid-career but a considerable younger contingent
Current leadership	Almost all	Almost all	Almost all	Almost all
Prior training and mentoring	**Half**	Few	Few	Few
Reasons for applying	Leadership skills	Leadership skills 1/6 vague or "was volunteered"	Leadership skills **Network** **¼ vague or "was volunteered"**	Leadership skills **Career develop.** **¼ vague or "was volunteered"**
Expectations from program	Leadership skills **Advocacy skills**	Leadership skills	Leadership skills **Network**	Leadership skills **Confidence**
Identity	(Not available)	Moderate identification as leader	**Highest identification as a leader**	Lowest identification as a leader
Satisfied, Supported, Able to Grow	Very	Very	**Moderately to Very**	Very
Committed	Very	**Moderately to Very**	Very	Very
Optimistic	Very	Very	Very	Very
Knowledgeable	(Self not asked) Policy Best practice Advocacy	Self Policy Best practice	Self Policy Best practice	Self Policy Best practice

Confidence	Highest= Asking for help Analyzing ?? Strategic thinking Engaging Execs Controversy Lowest=Advocacy	Highest= Asking for help Analyzing Collaborating Communicating Controversy Engaging Execs Engaging families Lowest=Advocacy	Highest= Visioning Analyzing Asking for help Collaborating Communicating Controversy Lowest=Advocacy	**Average confidence a bit lower** Highest= Using tools Visioning Collaborating Communicating Controversy Lowest=Advocacy
Networked	Moderate	**Lowest agreement**	Moderate	**Highest agreement**

Source: Analyses of application data and pre-program survey data

III. VIGNETTES OF EACH OF THE FOUR PRIMARY CARE LEADERSHIP PROGRAMS

Harking back to the study's foundational document (Taylor & Joftus, 2017), this section addresses what we described there as the What, Why, Where, When, Who of each of the four primary care leadership development programs in turn. (How leadership is developed by the program and how programs are being implemented will be addressed in our next brief.) Below, we provide more detailed information on **what** each program is (the main objectives, foci, and components of each leadership development program), **where and when** in the development of leadership they focus, **why** they do what they do (their theory of how their program develops leadership capacities), and **who** they are working with (in terms of recruitment and selection processes, numbers of participants, their backgrounds, and their leadership capacities before the program began).

CCHN Emerging Health Care Advocate Program

What is the program?

CCHN in partnership with the Colorado Center for Nursing Excellence was the first in this series of grants awarded by CHF in early 2017. However, CCHN delayed the start of its program to rework the program design and to extend recruiting efforts. The redesigned training activities commenced with a small cohort of 16 participants in late January 2018 and are scheduled to continue until March 2019. The program has a special focus on rural areas, giving priority to applicants from 15 counties in the southeast of Colorado.

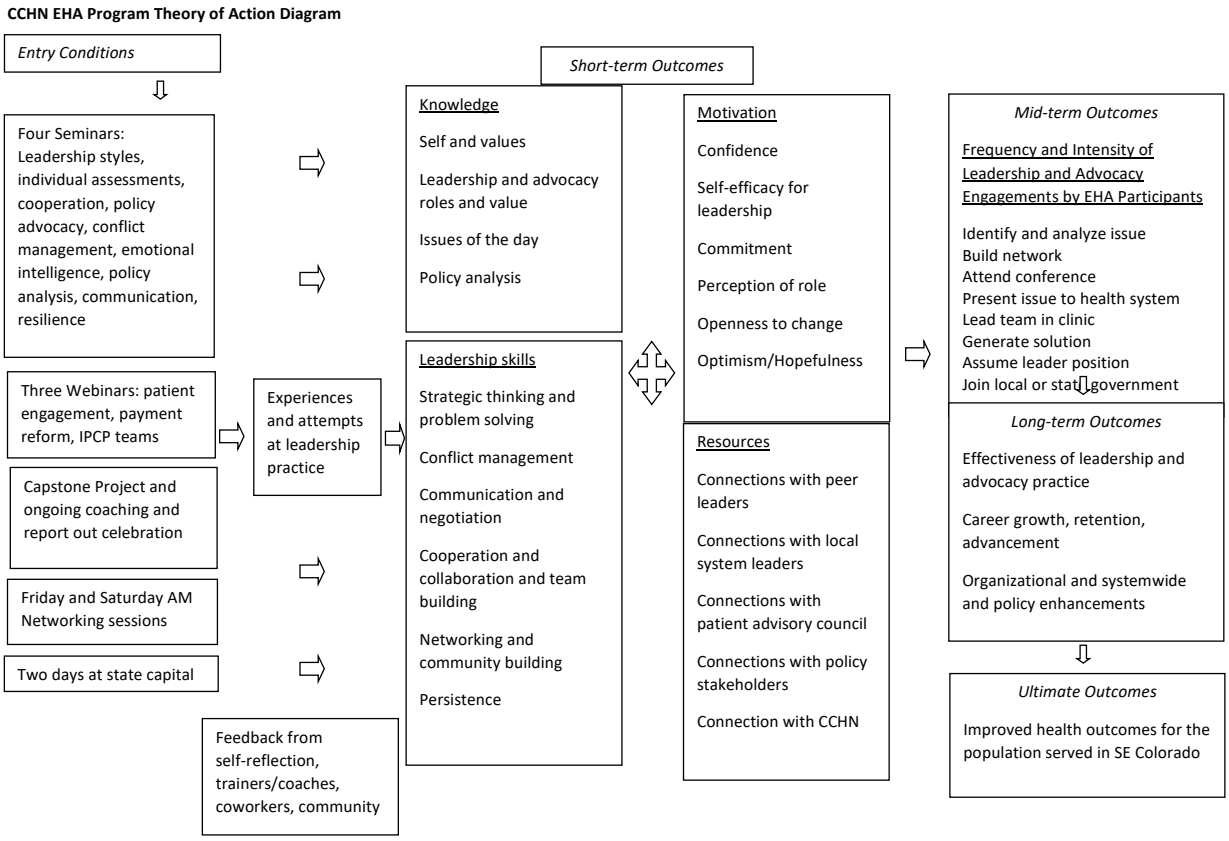
CCHN's program covers a range of arenas of leadership, from participants' personal individual practice and local practice to the networking arena to the broadest arenas of the medical field at large and policymaking (see Taylor & Joftus, 2017). CCHN's program design places an especially strong and sustained focus on advocacy and policy. As the use of "emerging" in the program name indicates, CCHN's program is intended to focus on the early or inspirational phases of participants' leadership and advocacy. CCHN described its program's content in the initial application as follows:

> "The content is focused on four priorities: 1) Leadership Development Skills and Tools; 2) Public Policy and Advocacy; 3) Peer and Cross-Sector Networking; and 4) Quality and Best Practices. The program begins with individual leader assessments to grow awareness and covers leadership styles, values, emotional intelligence, collaboration and working within interprofessional teams and groups; negotiation and influencing; creating a safe and civil environment; healthy boundaries and dealing with change, conflict and change fatigue. Public policy and advocacy content will include examination of current federal and state health policy trends; training on effective communication and advocacy strategies for legislators and media; and creating a path to becoming a leader and advocate. The peer and cross-sector networking will be intentionally designed and spaced throughout the program to expose participants to state and federal leaders across industries for shared learning and developing relationships. Finally, the quality and best practices curriculum will provide a big-picture view of advocacy by examining best practice models for primary care reform, integration and transformation; patient and employee engagement; using information technology and data to inform conversations, social determinants of health and continuous quality improvement. The content will be blended using experiential learning techniques and a capstone project to integrate skills and knowledge."
>
> *Source: CCHN document*

The theory diagram in Figure CCHN1 below lays out how CCHN's Emerging Health Care Advocate program moves from the entry conditions of participants (e.g., pre-existing leadership skills and

activity prior to program participation) all the way through to the ultimate desired outcome of improved health outcomes for the population served.

Figure CCHN1



CCHN's Emerging Health Care Advocate program is an intensive, multiple-component training extending over more than 65 contact hours and 13 months. Figure CCHN2 below describes the schedule of events planned for the CCHN program.

Figure CCHN2. CCHN Timeline

Event	Date
Recruitment	By December 2017
Webinar	January 24, 2018
Webinar	January 31, 2018
In-person Policy and Issues Forum at Capitol, Denver, CO	February 7-8, 2018
Coaching	March 2018
Webinar	March 14, 2018
In-person training, La Junta, CO	April 28, 2018
Coaching	May 2018
Webinar	May 16, 2018
In-person training, La Junta, CO	June 16, 2018

Coaching	July 2018
Webinar	August 2018
Coaching	September 2018
In-person training, La Junta, CO	September 29, 2018
Webinar	October 2018
Coaching	November 2018
Webinar	December 2018
Coaching	January 2019
Completion of Capstone Project	By February 2019
In-person Policy and Issues Forum and Capstone Celebration, Denver, CO	February 2019

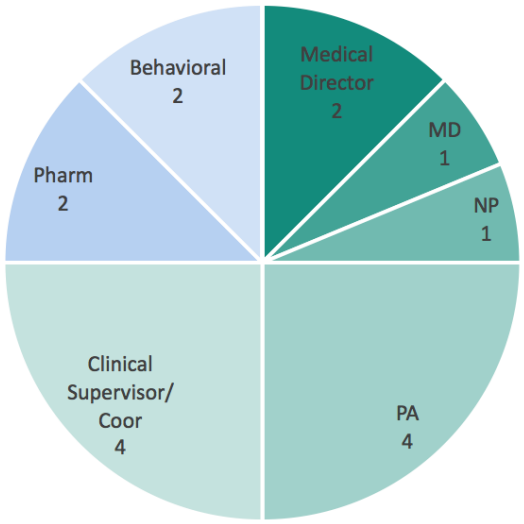
Source: CCHN program document

Who are the participants?

Background

The CCHN cohort of 16 participants is skewed toward higher-level positions, with no LPNs, MAs, or administrative staff (see Figure CCHN1). The cohort includes 2 pharmacists and 2 behavioral health clinicians. Four participants report 10 or more staff reporting to them, six report supervising 3-9 staff, and six report 0-2 staff reporting to them.

Figure CCHN3. CCHN Cohort's Distribution of Participants by Position



Position	Count	Total
Medical Director	2	12
MD	1	
NP	1	
PA	4	
RN	0	
Clinical Supervisor/ Coordinator	4	
Pharm	2	4
Behavioral	2	
LPN	0	0
MA	0	
Admin	0	
Total		**16**

Source: Preprogram survey data

As noted above, CCHN's program focuses on rural clinicians in Southeast Colorado. The cohort is two-thirds female, two-thirds white, and most cohort members have 5-10 years experience with their organization.

In CCHN's cohort, 15 of 16 participants said they currently provide primary care leadership. The large majority of participants reported leadership in the clinical realm (e.g., running the clinic floor, directing and advising clinical protocols, oversee operations and nursing, clinical supervision), two noted committee positions, two mentioned additional administrative posts, and two explicitly reported serving as a mentor (Q9).

Approximately half of CCHN's participants (7 of 16) said that during the past two years they had attended training in primary care leadership and 5 said that they met regularly with a mentor in their organization (Q12, Q10). Similarly, approximately half (7 of 16) said that they had advocated for policy or programmatic change in primary care in the past two years (Q11).

What were their reasons for applying and expectations for the program?

The predominant reasons for participating in the EHCA program were to *strengthen* leadership skills and *learn new* advocacy skills. The emphasis has been added to highlight that respondents' comments (from 12 of 16) repeatedly referenced honing existing leadership skills and acquiring not yet developed advocacy skills (Q13). Seven respondents stressed learning advocacy or developing an advocacy voice alone and 5 more mentioned the combination of acquiring advocacy skills and honing leadership skills, only one reported leadership skills alone. Two of these also highlighted developing understanding of policy as well. The remaining 4 participants reported reasons including to make a broader impact, to advance patient care and to work for equity.

Similarly, the large majority of participants (11) expected the program to develop in them advocacy and communication skills or a "voice" (Q14).

What was participants' pre-program status on intermediate outcomes?

As discussed above, the programs intend to improve several of their participants' capacities that in turn are believed to make them more likely to be strong leaders and advocates for primary care improvement. To understand participants' skills before starting the training program, we measured their status at baseline on several of capacities: identity as a leader and advocate, satisfaction with their work, commitment and optimism about improvement of primary care, knowledge, confidence, and network. We describe their pre-program status on these capacities below to describe the cohort but also so we can later assess whether participants' capacities have changed post-program, potentially as a result of participating in the program.

Identity

The pre-program survey did not contain items measuring self-identification as a leader or advocate.

Satisfaction, support, able to grow

A majority of CCHN participants reported feeling very satisfied, very supported, and very able to grow professionally in their current position at their organization at the outset of the training (Q15,16,18).

Commitment and Optimism

More than two-thirds (11 of 16) reported being extremely committed to "overcoming obstacles that delay the improvement of primary care" with the other 5 being very committed. However, the group was somewhat less sanguine that leadership and advocacy will improve primary care, with 6 moderately, 4 very, and 6 extremely optimistic (none were slightly or not at all optimistic). Resilience is another intended outcome of the EHCA program and over half "agreed" and very few (0-3) disagreed with statements describing themselves as resilient (Q28).

Participants saw the amount of time required as the largest barrier (somewhat of a barrier or a moderate barrier) to their ability to engage in advocacy (Q25).

Knowledge

Participants reported being least knowledgeable about advocacy (consistent with their reasons and expectations for participation in the program), next least knowledgeable about best practice models, and most knowledgeable about "current top national policy issues affecting CHCs" (Q23).

Confidence

Participants had higher confidence in their leadership abilities and strategic thinking skills than in their advocacy skills (Q24,26,27). Their highest level of confidence in specific leadership skills was in asking for help when they need it (4.13 on a scale running from 1 to 5). Their lowest level of confidence was in dealing with controversial or sensitive issues or managing conflict (3.19) and in garnering engagement and support from executives (3.19). This confidence was still as high as their confidence in any advocacy skill, the highest being engaging patients, families, and community organizations (3.19). They reported lower confidence speaking to external entities and giving presentations (2.63, 2.69).

Network

At baseline, most participants (9 of 16) made 6-10 new professional network connections in the past year. Participants were less and less confident in their ability to network as they moved farther outside of their organization from within their clinic or organization where they had somewhat high confidence in interacting with individuals in other Community Health Centers, partner organizations, or the community at-large (Q30).

JSI Emerging Leaders Team Based Care Program

What is the program?

JSI's Emerging Leaders (EL) program was developed out of the preexisting Learning from Effective Ambulatory Practice (LEAP) initiative and was designed as a professional development and mentoring opportunity in leadership for 23 early- to mid-career patient care staff and providers to build on team based care (TBC) initiatives.

The Emerging Leaders program obviously focuses on the early or inspirational phase of leadership development and targets on average less senior providers as participants. But the program does not ignore the potential longer-term outcomes of the training, intending that participants accelerate their development as leaders of local change and eventually sustain TBC within their organization, become resources on TBC to other sites, and become local and national role models of leaders in their job category.

JSI's TBC EL program has five immediate goals, each with a set of activities designed to reach that goal (see Figure JSI1).

Figure JSI1. Description of the CO TBC Emerging Leaders Program Five Main Components

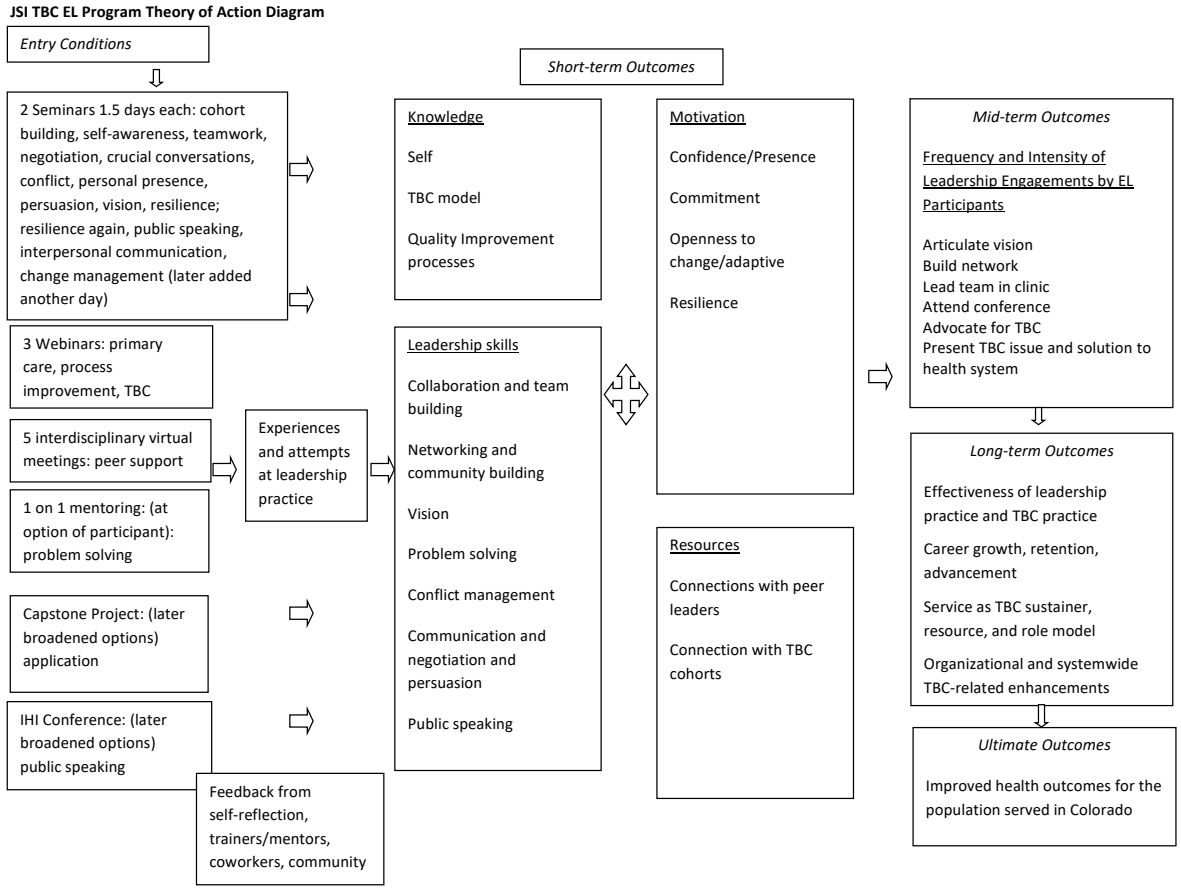
Component Goal	Method	Examples of Content to be Covered
1. Reflect on and develop personal leadership capabilities	Two in-person, 1.5 day long training events focusing on leadership skills in partnership with consultants Grace Cleaves and Laura Moorhead at Beyond Clinical Competence, LLC (BCC). Two executive coaching sessions with consultants from BCC.	Self-awareness and personal integrity; interpersonal communications & emotional intelligence; teamwork and collaboration; creating and conveying a compelling vision; personal presence and persuasion; managing change; influencing others; and resiliency.
2. Learn about the current state and future of primary care from national experts	A webinar series with leaders of primary care tackling content areas of importance to Emerging Leaders in primary care.	Building Blocks of High-Performing Primary Care Primary Care citizenship: assuring whole person care and acting as a community resource (includes SDOH; clinic-community connections) What does an organization have to do to continually improve? Lessons in measurement, process improvement and culture How do we best care for the Chronically Ill

		Health Policy and PC
3. Apply lessons learned to the practice context and practice collaboration in interdisciplinary teams	Five interdisciplinary team-lead webinars for participants to apply what they learned in the in-person training sessions and expert webinars to their practice; practice facilitating discussion among the diverse Emerging Leaders cohort; and practice presentation development skills. As well as an optional Capstone project supported by mentors.	Matched the content sequence from components one and two above.
4. Problem-solve current challenges through 1 on 1 mentorship	Emerging Leaders will select a mentor from a list of senior leaders in health care for the duration of the program.	Topics presented by Emerging Leader program participants.
5. Practice public speaking and presentation skills	The Emerging Leaders will collaborate with other EL in small groups to develop and lead a presentation at a local, regional or national conference. Additional public speaking coaching will be provided by mentors and faculty for interested participants. Presentations at EL virtual meetings.	Innovations in team-based care.

Source: JSI document

JSI's EL program has a theory of action that, as we currently understand it, uses a variety of training components to provide participants with exposure to knowledge, practice with skills, motivational supports, and a major attempt at application of the new skills especially around the practice of team based care (See Figure JSI2).

Figure JSI2.



JSI's schedule of activities (see Figure JSI3) was designed to take advantage of virtual technology to reach and connect participants, with only two in-person events and many webinars and virtual meetings. Note that this represents the initial planned timeline. As is often the case, the program adapted their set of activities to their participants' needs and as of June 2018 added a Clinicia Institute visit to observe team based care in action, added an in-person training in October, and broadened the options for how participants do their projects and when and where they present on their projects.

Figure JSI3. Activities for the JSI CO TBC EL Program and their expected timeline

Event	Date
Completion of pre-program survey by nominators and EL December Kickoff meeting with EL and nominators	January 10 (12-1 PM) 2018
Selection of mentor and initial call with mentor	January/February
First EL in-person leadership training session	January 22 (full day) & 23 (half day)
EL first virtual meeting	February
PC Leadership webinar series (1st content webinar)	March
Team Based Care Initiative Learning Forum	April 11 & 12

Second EL in-person leadership training session	May 16 & 17
EL second virtual meeting	June
PC Leadership webinar series (2nd content webinar)	July
EL third virtual meeting	August
PC Leadership webinar series (3rd content webinar)	September
EL fourth virtual meeting	October
PC Leadership webinar series (4th content webinar)	November/December
EL fifth virtual meeting/Presentation of Capstone projects	January 2019
Presentations at Conferences (depends on the conferences selected)	October 2018 – March 2019
Final Celebration	March 2019
Completion of post-program surveys by nominators and EL	March 2019
Conduct completion interviews with nominators and EL	April 2019

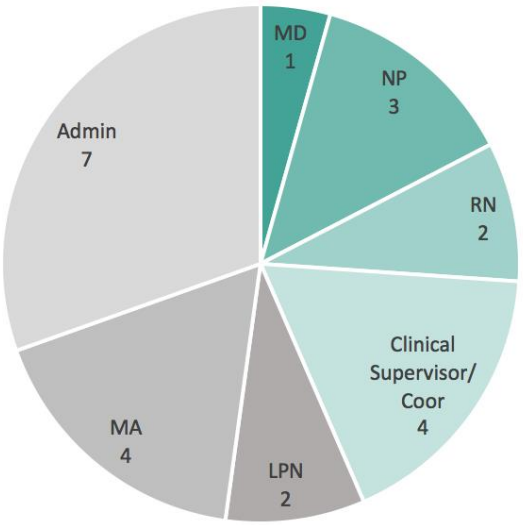
Source: JSI document prior to June 2018.

Who are the participants?

Background

The JSI cohort of 23 participants is skewed toward relatively lower level positions such as LPNs, MAs, and administrative staff. The cohort includes no clinicians practicing in complementary areas (e.g., dentists, pharmacists, behavioral health clinicians).

Figure JSI4. JSI Cohort's Distribution of Participants by Position



Position	Count	Total
Medical Director	0	10
MD	1	
NP	3	
PA	0	
RN	2	
Clinical Supervisor/ Coordinator	4	
Pharm, Psych, Behavioral, Dental	0	0
LPN	2	13
MA	4	
Admin	7	
Total		**23**

Source: Preprogram survey data

The cohort members are located in diverse settings depending on the preexisting TBC initiative sites. Two-thirds of the cohort are female, two-thirds are white, and the majority are mid-career with several years of experience.

JSI cohort members are currently practicing leaders who have not been formally trained to lead, at least in recent years. Almost all (18 of 23) said they currently provide primary care leadership. Only 4 had attended training in primary care leadership, and only 8 met regularly with a mentor in their organization during the past two years. Advocacy was not a focus of this program.

What were their reasons for applying and expectations for the program?

About half of the JSI cohort said that they decided to participate in the program to develop leadership skills (5) or to grow in their role (6). On the other hand, 4 indicated that they 'were volunteered' or had little input into whether they participated in the program. The most common response about what they expect to develop in the program was leadership skills of some sort. Three cohort members said they didn't know what to expect.

What was participants' pre-program status on intermediate outcomes?

To understand the extent to which JSI cohort members possessed leadership capacities upon entry into the program, we asked a series of brief questions about their self-identification as a leader, satisfaction with their current position, commitment and optimism, knowledge, confidence, and professional network.

Identity

When we asked whether they agreed with the statement "I am a leader in the area of primary care in my organization" 11 agreed, 7 disagreed, and 5 neither agreed nor disagreed. Although this program did not focus on developing advocacy, more JSI cohort members (14) agreed with the statement "I act as an advocate for the improvement of primary care in my organization."

Satisfaction, support, able to grow

The cohort entered the program feeling "very satisfied and supported and able to grow" in their current position and organization (3.73 on a 5 point scale, 15 or more of the 23 respondents marking "very" or "extremely" on the 3 items).

Commitment and optimism

The cohort entered the program agreeing that they were able to apply their commitment in their work (3.65 on a 5-point scale) and "very optimistic" (3.95 on a 5-point scale).

Knowledge

Most cohort members (15 of 23) agreed they had knowledge of their own strengths and weaknesses, but fewer agreed that they had knowledge of major policy issues (7) or best practice models (6) in primary care.

Confidence

Participants had higher confidence in their leadership abilities (analyzing, asking for support, giving guidance, using tools, collaborating) than in their skills in engaging executives or including parents, families, and community organizations in primary care improvement initiatives. Their highest level of confidence in leadership skills was in reaching out to ask for professional support, guidance, and tools from others and in analyzing alternative plans of action for solving a problem, where they were "very" confident (3.91 and 3.86 on a 5-point scale, respectively) even before the program began. In communicating and dealing with controversial issues, they were "moderately to very" confident. Engaging executives and families were the two lowest reported areas of confidence where they said they were "moderately" confident.

Network

The cohort's lowest average response (3.14 on a 5-point scale) on any area (and therefore a potential area for growth) was an average "neither agree nor disagree" response to the statement "I have a strong network of colleagues both inside and outside my organization who I can work with to improve primary care."

CCL Rural Colorado Primary Care Leaders Program

What is the program?

CCL in partnership with Colorado Rural Health Centers was awarded a grant from CHF in fall of 2017 and began training activities with 50 participants split into two cohorts in June 2018. The program is scheduled to continue through April 2019.

The program has a focus on the early or inspirational phase of leadership development for rural clinicians from across the state. CCL's program targets leadership development broadly from the personal arena to local practice to larger networks and the policy arena.

CCL's program targets several objectives including developing several competencies intended to support exercise of leadership, collaboration, teaming and networking, as well as advocacy (see Figure CCL1).

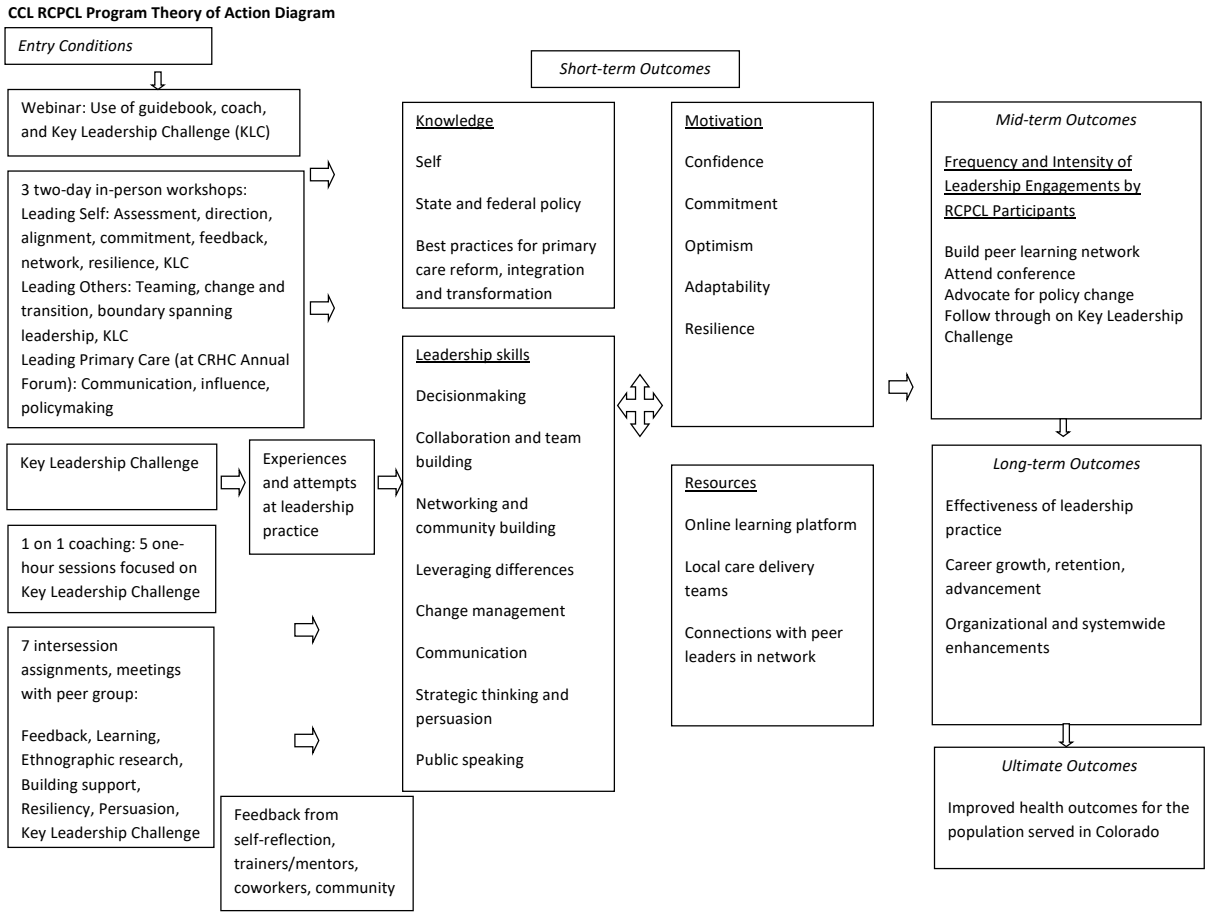
Figure CCL1. Measurable Competencies from CCL's Benchmarks

Leading Self	Leading Others	Leading Primary Care
Self-Awareness *Has an accurate picture of strengths and weaknesses and is willing to improve.*	Recognizes trade-offs *Recognizes that every decision has conflicting interests and constituencies and balances short- term pay-offs with long-term improvement.*	Building collaborative relationships *Builds productive working relationships with co-workers and external parties.*
Adapts *Can adapt to changing business conditions and is open to new ideas and new methods.*	Mentors others *Provides a climate that supports growth of others.*	Brings out the best in people *Has a special talent with people that is evident in his/her ability to pull people together into highly effective teams.*
Coping with pressure and adversity; integrity *Capable in high-pressure situations; resilient, optimistic, trustworthy.*	Leading change *Supports activities that position the business for the future; offers novel ideas and perspectives.*	Leveraging differences *Works effectively with people who differ in race, gender, culture, age, or background; leverages the unique talents of others to enhance organizational effectiveness.*
	Communicating effectively *Expresses ideas clearly and concisely; disseminates information about decisions, plans, and activities.*	Influencing, leadership, power *Good at inspiring and promoting a vision; able to persuade and motivate others; skilled at influencing superiors; delegates effectively.*
	Participative management *Involves others, listens, and builds commitment.*	

Source: CCL document

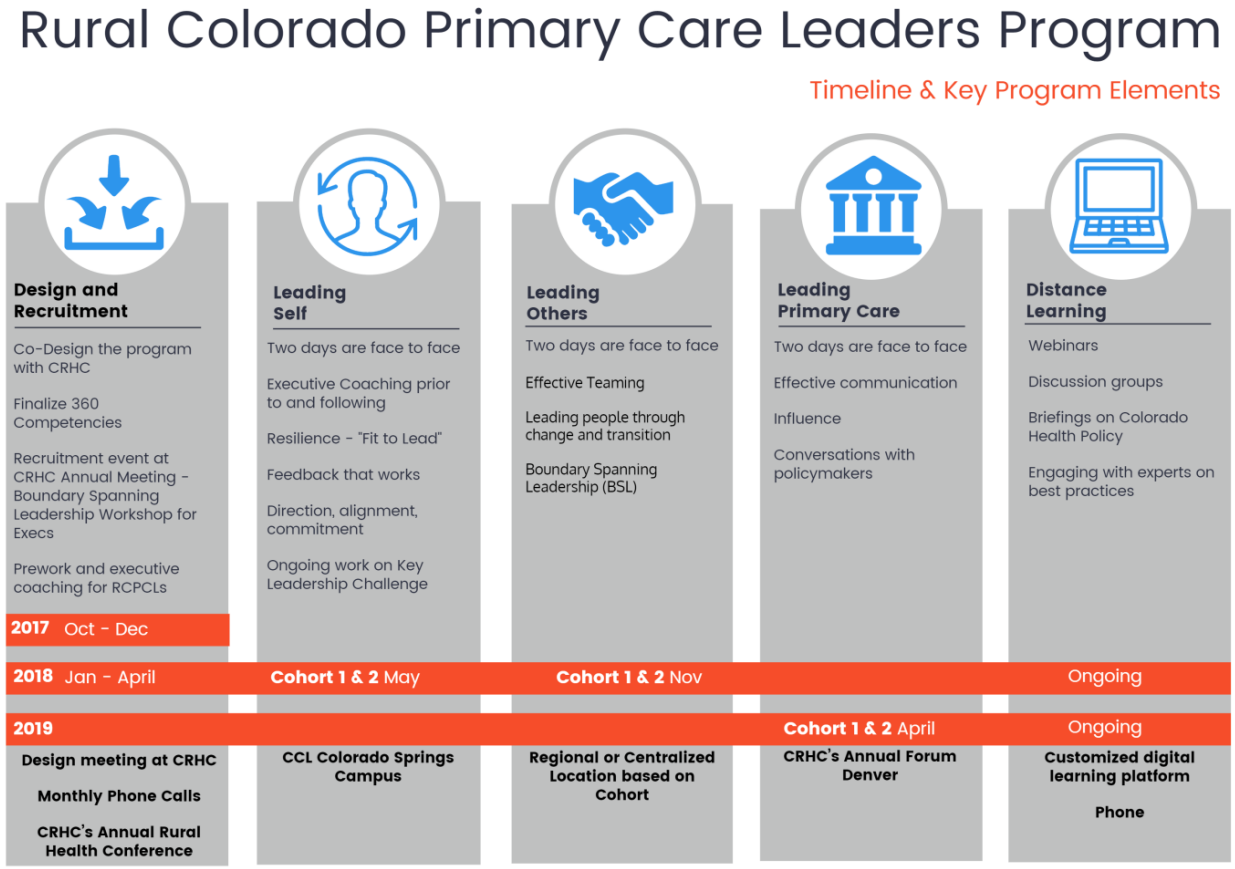
Our depiction of CCL's theory of action from entry conditions (e.g., participants' baseline characteristics) through training activities to short-, mid-, and longer-term outcomes is shown in Figure CCL2.

Figure CCL2



CCL's timeline of activities is focused around three two-day in-person workshops (see Figure CCL3). However, what Figure CCL3 does not show is the apparent centrality of the Key Leadership Challenge, which is addressed consistently across the program in the initial webinar, in-person events, coaching, and peer learning groups during intersession assignments. Furthermore, CCL's program attempts to engage participants and their peer learning groups in a substantial number (7) of intersession assignments during months when there is no in-person workshop.

Figure CCL3. CCL RCPCL Program Timeline



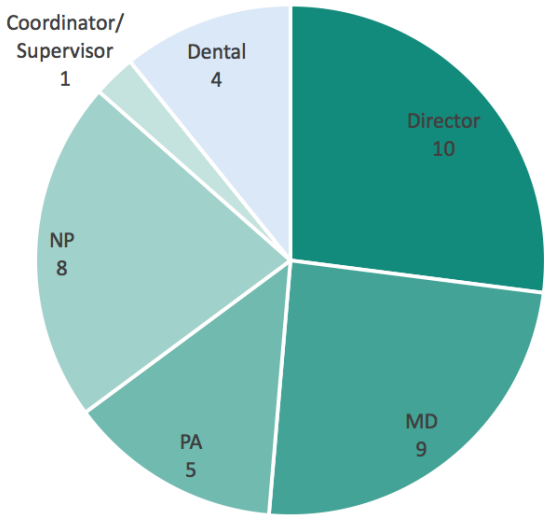
Source: CCL document.

Who are the participants?

Background

CCL has 50 participants and has split them into 2 cohorts. The CCL cohorts are rural and span the entire state. Senior positions such as Directors and Physicians are heavily represented in CCL cohorts, while there are no LPNs, Mas, or administrative assistants (see Figure CCL3). Forty of the 50 participants supervised others in their current position.

Figure CCL4. CCL Cohort's Distribution of Participants by Position



Position	Count	Total
Director	10	33
MD	9	
PA	5	
NP	8	
Coordinator/Supervisor	1	
RN	0	
Pharmacist	0	4
Mental Health (includes therapists and counselors)	0	
Behavioral Health	0	
Dental	4	
LPN	0	0
MA	0	
Admin/Receptionist	0	
Total		**37**

Source: Preprogram survey data

CCL's cohorts are mainly mid-career clinicians with an average of 6 years experience with their current employers, but there was a huge range from 4 months to 27 years. Eight of the 50 participants were in their first year with their current employer, while another 8 were in their 10th or greater year.

More than three-quarters of the participants said that they currently provided leadership, but less than half said they advocated for primary care improvement recently. Remarkably few participants (4 of 50) had attended leadership training in the past two years. Less than one-third has a regular mentor.

What were their reasons for applying and expectations for the program?

About one-third (12) of the 37 survey respondents said that their reason for enrolling in this program was to develop leadership skills. Another 6 indicated networking was a main reason, and 4 more said that career development was a reason. There was a range of other specific reasons reported, but it is notable that 7 provided extremely vague responses and 2 said that they were essentially "volunteered" by someone else to do the program, indicating that more than one-quarter of the cohort were likely not entirely clear about why they were enrolling in this program at the outset.

There was a broad spread of different expectations of what they would get from attending the program: The most frequent responses were to build leadership skills (7) or their network (6), but there were the same number of responses that indicated they were vague or didn't know what to expect from the program (6).

What was participants' pre-program status on intermediate outcomes?

Identity

On average (3.68), CCL participants agreed with the statement "I am a leader for the improvement of primary care in my organization" and agreed or *strongly* agreed (4.14) with the statement "I act as an advocate for the improvement of primary care in my organization."

Satisfaction, support, able to grow

As they entered the program cohort members indicated feeling very satisfied, moderately supported, and moderately able to grow in their current positions.

Commitment and optimism

The cohort entered the program "very optimistic" (4.03 on a 5 point scale) and feeling "moderately to very satisfied and supported" (3.53) in their current position and organization. They also entered the program very committed to overcoming the obstacles to improving primary care (4.08).

Knowledge

CCL participants agreed (3.76) at the outset of the program that they possessed self-awareness or knowledge of their own strengths and weaknesses in response to the statement "I understand my own strengths and weaknesses and how they play out in my work" but neither agreed nor disagreed that they had knowledge of best practice models in primary care (2.86) and knowledge of some of the major policy issues in primary care today (3.08).

Confidence

CCL participants' highest level of confidence was in analyzing alternative plans of action for solving a problem and in visioning, where they were "moderately" to "very" confident even before the program began. They were moderately confident in asking for help, collaborating, communicating, and dealing with controversy. Their lowest confidence was in advocating (2.30 or somewhat low confidence).

Network

Lastly, 41% of CCL participants believed (3.22) they had a strong network of colleagues inside and outside of my organization with whom they can work with to improve primary care.

RIHEL

What is the program?

RIHEL's Primary Care Movers and Changers program builds upon a prior established leadership training program known as the Advanced Leadership Training Program (ALTP) that has been adapted for this purpose. Developers indicate that the program has five key elements: a conceptual framework for leadership focused on behavior, individual assessments, an action learning experience, coaching, and reflection. RIHEL's leadership training program was requested to draw its participants from urban and suburban locales because two of the other funded contemporaneous programs had a rural focus. Following recruitment and selection, the 44 participants engage in a program that runs over the 12-month period from May 2018 to May 2019.

RIHEL's program focuses on a range of learning objectives and topics on leadership (styles, communication, teamwork), self-awareness, and advocacy action (see Figure RIHEL1).

Figure RIHEL1.

Learning objectives:

Participants can expect to learn about their own natural leadership style and how to harness it to create change. Practical skills like communication, influence, teamwork and leading change are taught. Plus, participants will have access to a peer coach and will work on a real-world advocacy project that makes sure ideas are translated into action. The in-person sessions help participants find collaboration and connection with fellow providers who seek to make a difference for patients and the greater healthcare community in Colorado.

Key program elements:

- A year long program
- Includes four 3-day events held at various locations in Colorado
- Each participant completes a 360-degree assessment of personal leadership practices and other self- assessments
- A peer coach is provided to each participant
- Participants advocate for the primary care changes they wish to see in Colorado
- Stipends are provided to mitigate travel or other expenses.

Topics studied and practiced include:

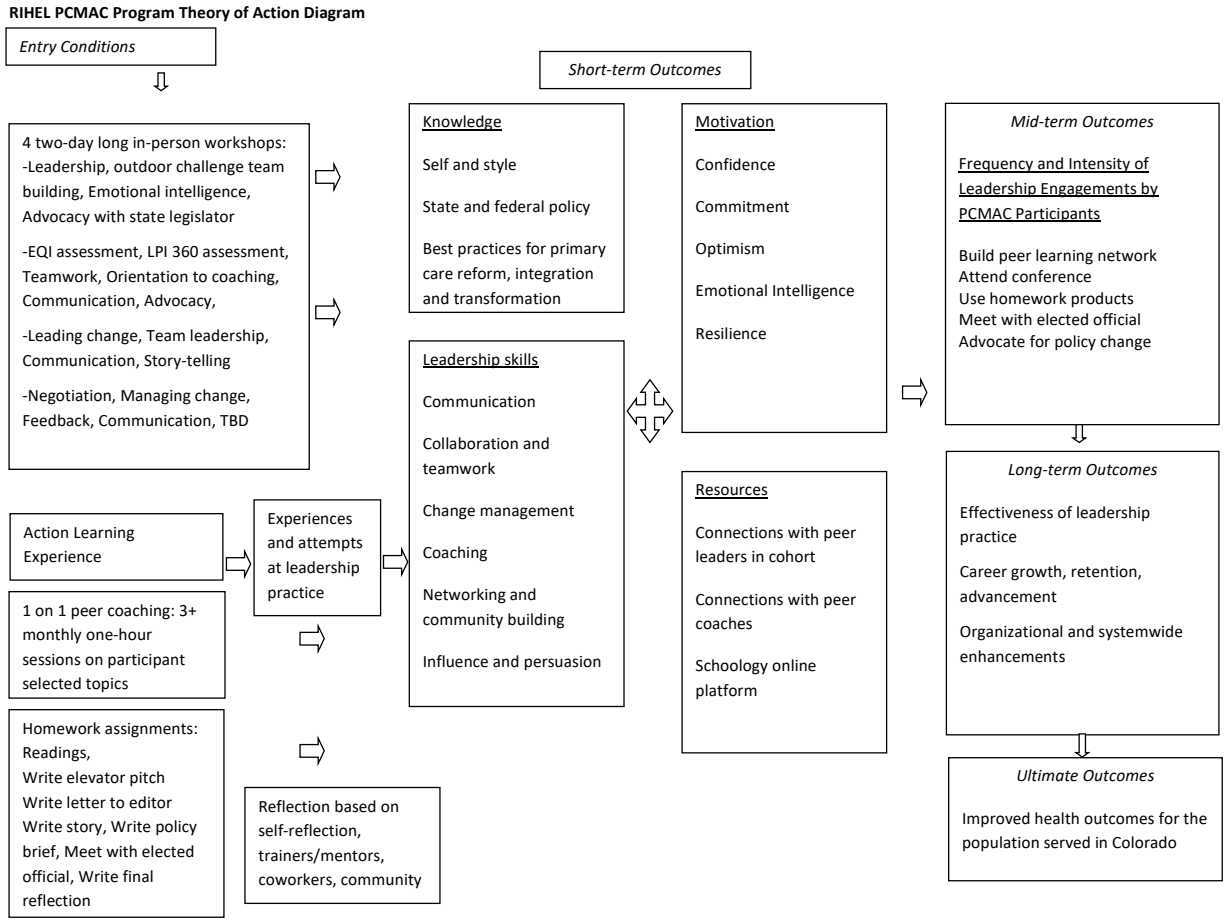
- Exemplary Leadership Practices
- Collaboration and Teamwork
- Leading Change
- Emotional intelligence
- Difficult Conversations
- Coaching
- Intentional Action for Leaders
- Crafting Effective Messages
- Communicating through the Media

Source: Two RIHEL documents

RIHEL's program focuses on developing participants during an early or inspirational phase of leadership across a broad range of leadership arenas, from individuals' personal leadership practice, to their work in their clinical and organizational settings, to their broader networks, and to the policy arena.

We have depicted a theory of action for the RIHEL program, as we currently understand it, to explore how training experiences may be translated into short-, mid-, and longer-term outcomes (see Figure RIHEL2).

Figure RIHEL2



RIHEL's configuration of program activities shows an early focus on individual assessments, followed by four extended in-person workshops (actually delivered over parts of three consecutive days), with interspersed monthly peer coaching sessions and several assignments or advocacy actions required to be completed outside of the other sessions (see Figure RIHEL3).

Figure RIHEL3. RIHEL PCMAC Program Timeline

Event	Date
Recruitment	By May 1, 2018
In-person 2-day workshop Florrisant, CO	May 4-6, 2018

Participants complete EQI assessment debrief with certified administrators	By June 30, 2018
Participants complete LPI-360 self assessment and assure 9+ observers complete their assessments	By August 15, 2018
Reading assignments	By September 6, 2018
In-person 2-day workshop, Estes Park, CO	September 7-9, 2018
Coaching – monthly	By January
Complete policy brief, letter to editor, elevator pitch, conduct meeting with elected official	By January
In-person 2-day workshop, Denver, CO	January 4-6, 2019
Coaching – monthly	By May
In-person 2-day workshop, TBD	May 3-5, 2019
Complete reflection on leadership development and advocacy actions	May/June, 2019
Graduation of the class	May/June, 2019

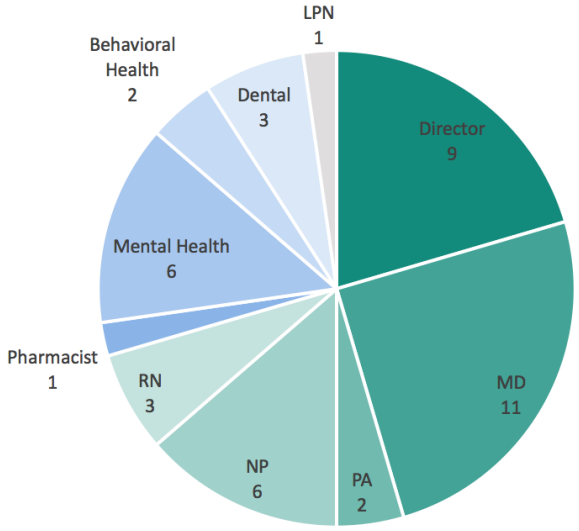
Source: RIHEL documents

Who are the participants?

Background

The RIHEL cohort of 44 participants is the most diverse set of clinicians, including 12 participants who work in the areas of pharmacy, psychology, mental health, behavioral health, or dental health. The cohort includes almost entirely higher-level staff with only one LPN and no MAs or administrative assistants.

Figure RIHEL4. RIHEL Cohort's Distribution of Participants by Position



Position	Count	Total
Director	9	31
MD	11	
PA	2	
NP	6	
Coordinator/Supervisor	0	
RN	3	
Pharmacist	1	12
Mental Health (includes therapists and counselors)	6	
Behavioral Health	2	
Dental	3	
LPN	1	1
MA	0	
Admin/Receptionist	0	
Total		**44**

Source: Pre-program survey

RIHEL's participants are mainly mid-career clinicians, but there is a considerable contingent, at least a quarter, who are early in their careers, and there are only about one in ten who are late in their careers. Three-quarters of the cohort are female and three-quarters are white.

More than three-quarters (38) of the participants said that they currently provided leadership, but just over half (23) said they advocated for primary care improvement recently. Few participants (8 of 44) had attended leadership training in the past two years.

What were their reasons for applying and expectations for the program?

Just less than one-quarter of the 44 survey respondents said that their reason for enrolling in this program was to develop leadership skills. A similar size group indicated that career development was a main reason, and another similar size group provided extremely vague responses or said that they were essentially "volunteered" by someone else to do the program, indicating that approximately a quarter of the cohort were likely not entirely clear about why they were enrolling in this program at the outset.

There was a wide spread of different expectations of what they would get from attending the program. The most frequent responses were to build their leadership skills (12) or their confidence (9), and the next largest group focused on building their advocacy skills (7).

What was participants' pre-program status on intermediate outcomes?

Identity

Although in relatively high-level positions and having responded that they provide leadership, the cohort was fairly reticent to self-identify as a leader. On average, the cohort neither disagreed nor agreed (3.16) with the statement "I am a leader in the area of primary care in my organization." The cohort was more comfortable identifying with advocacy, agreeing on average (3.73) with the statement "I act as an advocate for the improvement of primary care in my organization." However, it is possible that this statement may have been interpreted either as an advocate more broadly (as intended) or as an advocate for their patients (a relatively lower standard). Given that on the same survey they expressed less confidence in their advocacy skills than in any other area, it seems likely that most participants did not truly see themselves as a strong advocate for broad organizational and policy change when they entered the program.

Satisfaction, support, able to grow

The cohort entered the program feeling "very satisfied and supported" (3.73 on a 5-point scale) in their current position and organization.

Commitment and optimism

The cohort also entered the program "very optimistic" (4.09 on a 5-point scale) and "very committed" (4.18) to overcoming the obstacles to improving primary care.

Knowledge

RIHEL participants agreed that at the outset of the program they possessed self-awareness or knowledge of their own strengths and weaknesses in response to the statement "I understand my own strengths and weaknesses and how they play out in my work" (4.05) but neither agreed nor disagreed that they had knowledge of best practice models in primary care (3.02) and knowledge of some of the major policy issues in primary care today (3.20).

Confidence

RIHEL participants' highest level of confidence was in using tools such as technology and data, where they were "very" confident even before the program began. RIHEL participants reported the lowest confidence in their ability to advocate to public officials for primary care improvement (2.42, with three quarters of respondents marking low confidence or moderate confidence).

RIHEL participants reported somewhat lower confidence at entry to the program than participants in the CCHN and JSI programs (3.24 on the 5-point scale indicating a mean response that was just above moderate confidence and considerably below somewhat high confidence across 13 items).

Network

Participants generally agreed with the statement "I have a strong network of colleagues both inside and outside my organization who I can work with to improve primary care."

IV. HYPOTHESIS GENERATING FUNCTION OF THIS STUDY

One function of this study is to generate hypotheses that could be shared with program developers to prompt their thinking on how to design future programs or that could be examined systematically in future research on primary care leadership development programs. We will attempt to explore some of these ideas as we continue our data collection. We raise other ideas that we cannot directly address in order to move those ideas into future conversations among the foundation and program developers in the hope that those discussions spark ideas for improvement in primary care leadership development programs in the future.

Hypotheses

The less easily controlled components of the program such as coaching, peer group meetings, homework assignments, and the major projects will be the most variable in their implementation

and impact. Whereas the in-person and webinar sessions are managed by program staff and have dedicated time away from participants' normally hectic clinical responsibilities, other components require self-discipline and self- or peer-motivation and must compete with the normal day-to-day demands of a primary care provider's professional and personal life. When programs rely heavily on these less easily controlled components, they risk not covering the content or attaining the learning objectives targeted by those components. And it is precisely these less easily controlled components (e.g., coaching and projects) that are most likely to achieve transfer of ideas and behaviors from the training setting to the real-life day-to-day practice setting that is ultimately critical. A great deal may be learned about how to use these components as these programs attempt to implement them effectively.

Nonstrategic selection of participants will make program outcomes suboptimal, that is, less effective than they could have been using the same set of program experiences. As described in the section on recruitment and selection, the substantial logistical concern of reaching an intended quota in order to deliver the program took primacy over the strategic concern of generating a larger pool of applicants in order to select from them the individuals most likely to benefit from the program. This of course requires development of a profile of which individuals are most likely to benefit most from the specific leadership training program. In the education arena, Teach for America is a program that might generate lessons about recruitment and selection of participants.

"Volunteered and vague" participants may not be as successful as others. The participants who indicated that they did not have a clear reason for applying to the program stood out in stark contrast to most of the applicants who articulated a straightforward fit with the programs' focus on leadership and advocacy skills. They seem less likely to be a good fit for the program. The participants who indicated that they were essentially "volunteered" by someone else to join the program seem the least likely to be personally invested in the program and least likely to put forth the effort required to get all they can from the programs.

Some intermediate outcomes will not exhibit improvement because participants already top out before the program starts. Before the programs even started participants reported possessing several of the qualities the programs seek to develop. Participants report being very strong on several of the intended objectives of the programs: self-knowledge/awareness, commitment, optimism, working conditions such as job satisfaction, feeling supported, ability to grow, and confidence in a few of their leadership skills. If they are accurate in their self-assessments, it is likely that the program will not improve participants on these intermediate objectives at least as currently measured. However, it is possible that the participants overestimated their strength on these objectives and after experiencing the training they will reassess where they stand on these objectives. It is also possible that evaluators will be able to propose more sensitive measures for use in future research.

A network across the cohorts of these programs would be stronger than any individual cohort. Here we are asking how one might link the participants from (1) current and past iterations of these programs with each other and (2) across each of the four programs into a larger network. The benefits of networks are well known (Granovetter, 1973; Bryk et. al, 2016), and strengthening ties between the cohorts of primary care leaders and advocates could unleash those benefits.

For example, it is likely that a participant in one of these programs is working on a capstone project that could benefit from the resources of a participant in another one of these programs. Again, some policy or legislative initiatives for the betterment of primary care in Colorado will likely emerge from the work of one of these program participants, and they will as a result of their participation now be able to potentially enlist the support of 20 or so fellow cohort members who went through the program with them. Imagine if they could enlist the support of more than 100 primary care leaders from across the four current programs, and more so, the 100s of alumni members of prior leadership development cohorts from across the past few years of work by these four programs.

V. SUMMARY

The four CHF-funded primary care leadership development programs have been designed to be intensive, long-duration, fairly comprehensive leadership development trainings with robust sets of multiple components (e.g., in-person workshops, webinars, coaching, projects). Developers designed programs that were intended to individualize experiences, provide ongoing training, and provide experiential learning opportunities. Their recruitment and selection processes nearly attained their intended targets but were likely suboptimal in finding the participants who were most likely to benefit because they did not recruit strategically. Programs' participants held a mix of positions ranging from medical director to physician to LPN to administrative assistant. At the outset of the programs, participants were mostly mid-career accomplished professionals reporting that they already provide leadership in their organization, and already very satisfied, supported in their positions, and committed, optimistic, and confident in some areas of leadership. However, very few participants had been trained or regularly mentored in leadership recently, and few participants were knowledgeable about best practices or policy, or confident in more challenging leadership skills (such as communicating or dealing with controversy) and advocacy skills. Our next brief will examine the implementation of the four programs.

CITATIONS

Bryk, A., L. Gomez, A. Grunow, and P. LeMahieu (2016). Learning to Improve: How America's Schools Can Get Better at Getting Better. Harvard Education Press.

Granovetter, Mark S. (1973). The Strength of Weak Ties. *American Journal of Sociology,* Vol. 78, No. 6 (May, 1973), pp. 1360-1380.

Taylor, J. & Joftus, S. (2017). The Landscape of Primary Care Leadership. Washington, DC.

APPENDIX

Methods

This first brief draws primarily on the grant applications, a limited curriculum review, emails, developer interviews, participant application data, and the pre-program survey of participants.

Data Collection

At the earliest stage of the evaluation we spent time with each program's leaders and collected documents to try to understand their definitions of leadership and theories of action. Program developers provided their grant applications, program schedules, a sampling of planned curriculum materials, application data. We also gathered data as we observed several training events. Lastly, we administered a very short pre-program survey of participants.

Survey Response Rates

With the cooperation of each of the programs, the pre-program surveys were combined with each program's own initial application or participant survey administered before the training began. This both reduced burden and likely increased response rates relative to a stand slone evaluation survey. Response rates were as follows:

CCHN 100%

JSI 100%

CCL 74%

RIHEL100%

Pre-program Survey Items

The pre-program surveys varied, because they were a combination of program and evaluation items. Below is a set of items that were common to most surveys.

Leadership Development Survey

The next part of this survey is designed for a range of respondents across several primary care leadership development programs funded by the Colorado Health Foundation. For this reason, the content covered by a few of the survey items may not be covered in your particular program. If there is a question you do not want to answer or that does not apply to you, you may skip it, but we hope you will answer as many questions as you can. The survey is intended to gather your opinions prior to starting your program and the only right answers to these questions are your honest opinions. This survey is voluntary and confidential. Your opinions are very important to us, and we appreciate your participation in this survey!

1. What is your current job title?

_____

2. Do you currently provide leadership related to primary care? No Yes→ **If so in what way?**

_____

3. In the past 2 years, have you advocated for change in primary care? No Yes→ **If so please briefly provide an example of what you did?**

_____

4a. In the past 2 years, have you attended any training in primary care leadership? No Yes→ **If so please briefly provide an example of what you did?**

_____

4b. In the past 2 years, have you met regularly with a mentor in your organization? No Yes

5a. What are the main reasons that you decided to participate in this program?

_____

_____

5b. What do you expect to develop during your participation in this program?

_____

_____

6. Please indicate the extent to which you disagree or agree with the following statements:

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
a) I understand my own strengths and weaknesses and how they play out in my work.	○	○	○	○	○
b) I have a strong network of colleagues both inside and outside my organization who I can work with to improve primary care.	○	○	○	○	○
c) I understand the major policy issues in primary care today.	○	○	○	○	○
d) I understand best practice models for primary care reform, integration and transformation.	○	○	○	○	○
e) I am a leader in the area of primary care in my organization.	○	○	○	○	○
f) I act as an advocate for the improvement of primary care in my organization.	○	○	○	○	○

7. To what extent are you …

	Not at all	Slightly	Moderately	Very	Extremely
a) Satisfied with your current position?	○	○	○	○	○
b) Supported by organizational leadership in your current position?	○	○	○	○	○
c) Able to grow professionally as a leader within your organization?	○	○	○	○	○
d) Committed to overcoming the obstacles that delay the improvement of primary care?	○	○	○	○	○

	Not at all	Slightly	Moderately	Very	Extremely
e) Optimistic that leadership and advocacy will improve primary care?	○	○	○	○	○

8. Please rate your <u>confidence in your current abilities</u> in the following areas:

	Very Low Confidence	Somewhat Low	Moderate	Somewhat High	Very High Confidence
a) Developing and managing relationships effectively with diverse colleagues and stakeholders	○	○	○	○	○
b) Facilitating collaboration among people to accomplish goals on joint projects	○	○	○	○	○
c) Dealing with sensitive, controversial issues and managing conflict	○	○	○	○	○
d) Analyzing alternative plans of action for solving a problem	○	○	○	○	○
e) Looking beyond the day-to-day challenges to define a longer term vision	○	○	○	○	○
f) Communicating clear messages and key priorities to build commitment and guide the effort of others	○	○	○	○	○

8. (continued) Please rate your <u>confidence in your current abilities</u> in the following areas:

	Very Low Confidence	Somewhat Low	Moderate	Somewhat High	Very High Confidence
g) Garnering engagement and support from our organization's directors, executives and managers for primary care improvement initiatives.	○	○	○	○	○
h) Advocating to public officials for primary care improvement	○	○	○	○	○
i) Providing professional support, guidance and tools to others	○	○	○	○	○
j) Reaching out to ask for professional support, guidance and tools from others	○	○	○	○	○
k) Using tools such as technology and data	○	○	○	○	○
l) Finding ways to include patients, families and community	○	○	○	○	○

	Very Low Confidence	Somewhat Low	Moderate	Somewhat High	Very High Confidence
organizations in the improvement of primary care					
m) Engaging others in changes that will result in more effective and efficient clinical operations and outcomes	○	○	○	○	○