

NLAPH Cohort 1 Evaluation Report



Prepared by the:
Center for Community Health and Evaluation

May 2013

NLAPH Cohort 1 Follow-up Report May 2013

Table of Contents

I. Introduction	1
A. Program Description	1
B. Cohort 1 Description	2
C. Evaluation Methods	4
II. NLAPH Implementation	5
A. Program Curriculum & Delivery Components	5
B. Fidelity to Model	8
C. Program Delivery Components	13
1. Webinars	13
2. National Retreat	19
3. Coaching	21
4. Network Development	27
III. NLAPH Outcomes	30
A. Leadership Development	30
B. Team Development/Intersectoral Collaboration	40
C. Project Progress	45
IV. Recommendations	50
Appendix A: Timeline of Program Components	53
Appendix B: NLAPH Logic Model	54
Appendix C: NLAPH Cohort 1 Teams	55
Appendix D: Delivery of Intended Program Elements	57
Appendix E: Webinar Descriptions	58
Appendix F: Elective Webinars by Topic	60
Appendix G: Responses to Individual Webinar Objectives	62
Appendix H: Team Progress on Leadership Learning Goals	63
Appendix I: Increases in Leadership Competencies by Team	65
Appendix J: Summary of Team Culminating Reports	66
Appendix K: Recommendations from Participants	77

This report was prepared by the Center for Community Health and Evaluation (CCHÉ). CCHÉ designs and provides evaluation services for health-related programs and initiatives throughout the United States. CCHÉ is part of the Group Health Research Institute in Seattle, Washington.

I. Introduction

A. Program Description

The National Leadership Academy for the Public's Health (NLAPH) is a team-based applied leadership program focused on developing the leadership capacity of teams of leaders to promote community health improvement by working effectively across sectors. As part of their application, teams are required to identify a 'real world' community health improvement project that they will work on throughout the program. These projects provide real-life challenges for teams to address and serve as a testing ground for application of new leadership skills and approaches learned through the Academy.

The overall framework for the program includes a focus on both leadership—at the individual, collaborative, intersectoral and meta levels—and the design and implementation of intersectoral, evidence-based projects to address community priorities in prevention. Using an emergent design during the first cohort, the overall curriculum and other aspects of the program were developed along the way, providing an opportunity for greater alignment between implemented program and the needs of participants.

With teams located throughout the country, the program used a combination of in-person and distance learning. During the pilot year, the NLAPH consisted of four primary components:

- **Webinars:** monthly webinars featuring health leadership experts.
- **National Retreat:** a multi-day, onsite session involving participants, expert speakers, coaches, and program staff.
- **Coaching:** applied learning support provided by expert practitioners, to assist with application of curriculum elements based on individual, team, and project needs.
- **Network Development:** access to an NLAPH portal (phConnect) that was used for networking, archiving resources, consultation, and peer learning. Participants continued to have access beyond their year of participation to promote continued professional networking and peer learning.

The components were enhanced by the extensive use of nationally known organizations and experts to help design and deliver the curriculum. By enlisting leaders from the fields of community health, leadership, and systems and policy change, the intent was to expose participants to a wealth of knowledge, experience and insights to support and strengthen community health leadership.

The program was launched with the first cohort of participants in February 2012. A timeline of program components is included in **Appendix A**. Following the identification of specific knowledge, attitude and practice (KAP) elements considered to be of greatest importance to the program, a revised logic model was developed in July 2012 to reflect the inputs, outputs and intended outcomes of the NLAPH program (**Appendix B**).

B. Cohort 1 Description

As was reported in the baseline assessment and mid-year evaluation report, the inaugural cohort of the NLAPH included 20 teams, with four individuals per team. These 80 participants came to the NLAPH with a range of experience and represented diverse sectors. The community health improvement projects selected by teams also varied in scope, approach and community health focus areas.

1. Description of individuals & teams participating

- **Range of experience within their sector:** NLAPH participants had an average of 11.4 years of experience within their current sector, with a range of 0-37 years. Over 1/3 of the cohort reported 5 or fewer years in their current sector.
- **Range of leadership levels within their organization.** 36% led their organization or coalition; 41% led a division or department; and 10% led a team. (n=69)
- **Cross-sector experience:** In the baseline assessment, 80% of participants reported having done “some” or “a great deal” of work in sectors beyond that in which they were currently employed.
- **Representing diverse sectors:**
 - 53% of participants worked in the public sector, 44% worked in the non-profit sector, and 3% worked in the for-profit sector (n=64).
 - Over half of participants identified public health as their discipline (61%); other disciplines represented by more than one participant included: health care (29%), education/academia (10%), community services (5%), and mental health (3%) (n=59).
- **Teams are spread across the United States:** The 20 teams represented 15 different states; 5 states had two participating teams. See **Figure 1**. A list of the participating teams can be found in **Appendix C**.

C. Evaluation Methods

The Center for Community Health and Evaluation (CCHÉ) served as the NLAPH evaluator. Throughout the year, data were collected from multiple sources to assess NLAPH implementation and the resulting accomplishments. **Table 1** provides a summary of data collection activities.

Table 1: NLAPH Cohort 1 Data Collection

Data source	Data collection method	Timing
NLAPH participants – individual	<ul style="list-style-type: none"> Baseline & needs assessment individual survey (n=80) 	February-March 2012
	<ul style="list-style-type: none"> Post-retreat survey (n=75) 	May 2012
	<ul style="list-style-type: none"> Mid-term check-in survey (n=65) 	August 2012
	<ul style="list-style-type: none"> Follow-up individual assessment (n=70) 	February-March 2013
	<ul style="list-style-type: none"> Participant interviews (n=18²) 	January-February 2013
	<ul style="list-style-type: none"> Post-webinar surveys & summaries (n=19-66) 	Ongoing, after each webinar
NLAPH participants – team	<ul style="list-style-type: none"> Baseline team self-assessment (n=20) 	February-March 2012
	<ul style="list-style-type: none"> Follow-up team self-assessment (n=19) 	February-March 2013
	<ul style="list-style-type: none"> Culmination reports (n=20) 	January 2013
NLAPH coaches	<ul style="list-style-type: none"> Mid-term coach survey (n=8) 	August 2012
	<ul style="list-style-type: none"> Mid-term coach assessment of team readiness and progress (n=20, report on each team) 	September 2012
	<ul style="list-style-type: none"> Coach site visit reports & log entries 	Ongoing
	<ul style="list-style-type: none"> Coach interviews (n=8) 	January-February 2013
NLAPH advisors	Mid-year advisor survey (n=11)	August 2012
Other program documents	Document review: <ul style="list-style-type: none"> Curriculum models, competency sets & program logic model Retreat & webinar agendas and materials Participation data phConnect website 	Ongoing

² Interviews were conducted with 10 teams who were rated as having made progress by the coaches at the mid-term assessment. Teams were asked to identify two members of their team to participate in the interview process; it was strongly recommended that one of the interviewees be their team lead.

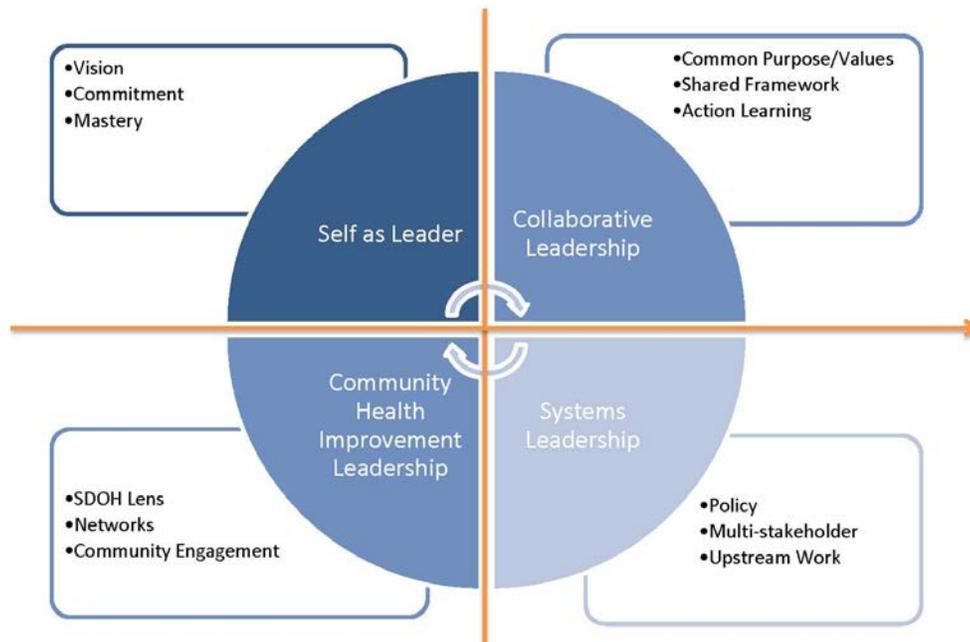
II. NLAPH Implementation

A. Program Curriculum & Delivery Components

As is often the case with pilot programs, the initial model was designed very broadly, and specifics emerged as the program unfolded.

The NLAPH curriculum model, as seen in **Figure 2**, was designed to address the leadership spectrum and the prevention/policy/systems change spectrum. Broken into four quadrants, the model reflected the NLAPH’s overall goal of developing leaders and leadership teams well-equipped to plan and deliver community health improvement projects that move up the spectrum to policy and systems change. The model identifies four levels of leadership: individual, collaborative, systems and community health improvement. Within each leadership quadrant, a set of leadership qualities, attributes and approaches were identified. Together, these integrated leadership and prevention/policy/systems elements form the basic framework around which the initial NLAPH teachings were organized during Cohort 1.

Figure 2: NLAPH Curriculum Model



1. Refinement of the Curriculum Model

Two additional pieces of information helped to refine the curriculum model during the course of Cohort 1: (1) results of the baseline assessment indicating areas that participants were interested in further developing, and (2) a NLAPH Leadership Team strategic planning session held in June 2012.

(1) **Baseline Assessment Results.** The baseline assessment asked participants what areas they were interested in further developing. The results indicated that there were five broad areas of interest to participants in developing their leadership abilities. Although self-perceived current abilities were lowest in the first two, participants indicated a strong interest in all five being priorities for the program.

- **Planning, Analysis and Evaluation**, including technical approaches to community needs assessment, project planning, progress tracking, and evaluation.
- **Success in Political Environment**, including ability to lead in a politically charged environment, ability to obtain political and financial support, understanding of the legislative process, and ability to influence policy.
- **Leadership and Effectiveness**, comprising effective decision-making processes, creating shared vision, creating and sustaining trust, and exercising effective organizational leadership.
- **Community Strengthening and Engagement**, covering areas such as ability to identify key stakeholders, to work with diverse ethnically and racially diverse communities, and to engage community-based leaders and organizations.
- **Communication**, including capabilities on both the organizational and individual-levels.

(2) **NLAPH Leadership Team Strategic Planning Session.** In June 2012, the NLAPH Leadership Team conducted a strategic planning session. Using the original curriculum model and feedback from the baseline assessment, the team identified a set of specific Knowledge, Attitude and Practice (KAP) elements to be addressed by the program. These KAPs address five distinct domains, and within each of these domains, a set of specific competencies were developed. (See **Table 2**).

Table 2: NLAPH Competency Areas

Domain	Competency Area
I. Individual Leadership Mastery	<ol style="list-style-type: none"> 1. Self-awareness – styles, behaviors, strengths and weaknesses – self and team members 2. Builds trust 3. Communicates effectively 4. Builds teams 5. Manages change and conflict 6. Takes systems approach
II. Ability to Work Effectively Across Sectors	<ol style="list-style-type: none"> 7. Builds networks 8. Engages community & diverse stakeholders 9. Values collective impact
III. Application of Continuous Quality Improvement Principles	<ol style="list-style-type: none"> 10. Seeks and applies learning
IV. Appropriate Use of Data for Assessment, Planning, Monitoring and Evaluation	<ol style="list-style-type: none"> 11. Gathers, collects and utilizes high quality data for planning and decision-making 12. Effectively uses data to influence others
V. Commitment to a Public Health Perspective	<ol style="list-style-type: none"> 13. Aware of and committed to Social Determinants of Health (SDoH), Health in All Policies (HiAP), health equity 14. Is politically savvy

2. Components of the Delivery Model

To address these competency areas, the following components and characteristics were key elements of the delivery model:

1. **Applied, team-based collaborative leadership training model**, emphasizing multi-sectoral teams and community health improvement projects.
2. **Flexible program design**, including core and elective curriculum elements, guided by a baseline needs assessment.
3. **On-site and distance learning modalities**, including: web-based trainings; in-person national retreat; and coaching support to teams; with use of didactic sessions, case examples, exercises/activities, and feedback/support.
4. **Promotion of networking opportunities for participants.**
5. **Use of experts and partners** from around country to inform programming and facilitate webinars.

B. Fidelity to Model

The evaluation sought to understand the extent to which the program, as implemented, demonstrated fidelity to the proposed program model. As is often the case with pilot programs, the initial model was designed very broadly, and specifics emerged as the program unfolded. For this reason, the assessment of fidelity of implementation focused on alignment between (1) the original model and new competency domains, (2) the components of the delivery model and what was implemented, and (3) the topics covered in the core curriculum sessions and competency domains. The evaluation also assessed participant and coach satisfaction and their perceptions of contribution of the NLAPH to leadership growth.

1. Alignment between original curriculum model and revised competency domains

As discussed above the curriculum evolved during the pilot year, however, the core components remained relatively consistent. **Table 3** crosswalks the curriculum model (Figure 2) with the 5 domains identified in the baseline assessment and the new competency sets that resulted from the strategic planning process in the summer of 2012 (Table 2). All areas identified in the early model are still covered within the new, with a number of previously distinct categories (e.g., systems leadership, community health improvement leadership, and prevention/policy/systems change) now falling within a broader domain (Commitment to Public Health Perspective). In addition, two new domains have been added: one on the use of data, and another on continuous quality improvement. The former had emerged as a key need/priority in the baseline assessment, while the latter was a new element. Taken as a whole, this suggests that the current curriculum model has maintained close fidelity to the general curriculum model proposed early on despite the mid-course modifications and refinements.

Table 3: Crosswalk of Competency Domains, Curriculum Model & Baseline Results

New Competency Domains (Table 2)	Original curriculum model (Figure 2)	5 domains from baseline assessment
I. Individual Leadership Mastery	<ul style="list-style-type: none"> Individual leadership 	<ul style="list-style-type: none"> Leadership and effectiveness Communication
II. Ability to Work Effectively Across Sectors	<ul style="list-style-type: none"> Collaborative leadership 	<ul style="list-style-type: none"> Community and stakeholder engagement
III. Application of Continuous Quality Improvement Principles	N/A	N/A
IV. Appropriate Use of Data for Assessment, Planning, Monitoring and Evaluation	N/A	<ul style="list-style-type: none"> Planning, analysis and evaluation
V. Commitment to a Public Health Perspective	<ul style="list-style-type: none"> Systems leadership Community health improvement leadership Prevention/policy/systems change 	<ul style="list-style-type: none"> Success in political environment

2. Alignment between program delivery components and implementation

In general, NLAPH was implemented using the five key elements of the delivery model discussed above. Twenty multi-sectoral teams participated using selected community health improvement projects to apply learnings (**applied, team-based collaborative training model**); the curriculum included core and elective curriculum elements that were responsive to the baseline needs assessment discussed above (**flexible program design**); they used a mix of **on-site and distance learning modalities** through the national retreat, webinars, and coaches' site visits and calls; they **promoted networking opportunities** through an online web portal (phConnect) and connecting teams to other experts and teams working on similar issues; and they **used experts and partners** as advisors, coaches, presenters to ensure that the curriculum reflected best practices and expert opinion. (See **Appendix D** for more details).

3. Alignment between core curriculum sessions and competency domains

A review of the sessions offered in the core curriculum illustrated that the core curriculum addressed all five competency domains. Over half (8/15) of topics covered concepts related to Individual Leadership Mastery. A third covered Ability to Work Effectively Across Sectors (5/15), and another third discussed topics related to Commitment to a Public Health Perspective. The Continuous Quality Improvement and Use of Data domains were covered, but less frequently (See **Table 4**). Links to elective webinars on many of these topics were provided to participants (see **Appendix E** for a list of elective webinars).

Table 4: Crosswalk of Core Curriculum Sessions by Competency Domain

Delivery	Session Title	Leadership Mastery	Intersectoral Collaboration	CQI Principles	Use of Data	Public Health Perspective
Retreat	Harvesting Experience in Collective/Team Leadership	X	X			
Retreat	Inner-Leadership: Understanding Self and Others	X				
Retreat	Growth and Change from the Inside Out	X				
Retreat	A 21 st Century Approach to Prevention: Opportunities for Improving Health & Safety and Promoting Health Equity					X
Retreat	Systems Thinking	X				
Retreat	Health in All Policies					X
Retreat	What Working with Other Sectors Means		X			
Webinar	Leadership Models We Can Learn From	X				
Webinar	Collective Leadership	X	X			
Webinar	Improving Community Health – Getting things Done	X				X
Webinar	Framing the Message	X				
Webinar	Tension of Turf- Tools for Intersectoral Collaboration		X			
Webinar	Why Policy Matters					X
Webinar	Got Data – Leading with a CQI Mindset			X	X	
Webinar	Sustainability Planning		X	X		
Total Curriculum Elements for Each Domain		8	5	2	1	4

4. Coach perception of NLAPH Program Model

The majority of coaches (7/8) expressed challenges with the evolving nature of the curriculum during their work with Cohort 1 teams. They indicated that this resulted in variation in coaching services—*“Coaches, lacking a [clear] curriculum, relied more on their own strengths and experiences.”* This created difficulty in aligning the real-time needs of NLAPH teams with the materials presented in the webinars. For example:

- *“It was hard to pull material presented through webinars and apply it to the issues they were grappling with. I wanted a little more alignment there.”*
- *“I’m still seeing some disconnect between the types of things we’re likely to be talking about at the retreat and in the webinars and the ongoing work with the teams. The teams will say these are important concepts, and I think folks enjoy them, but I’m not sure how they apply to the projects.”*

In response to mid-term feedback from coaches and other advisors, the NLAPH Leadership Team made changes to curriculum design and delivery for Cohort 2 of the NLAPH. Most coaches found the new curriculum to be more organized and appropriate, stating:

- *“I appreciate that [the curriculum] is so much more organized now. There’s a real logic around the core areas to focus on.”*
- *“I thought [the changes were] very thoughtful and responsive to the lessons learned from year one.”*

5. Participant satisfaction with NLAPH Program Model

While initially, participants reported being unclear about the NLAPH’s program focus, their understanding increased significantly by the mid-term assessment. At the end of the program participants reported a high level of satisfaction with the NLAPH program model and the strategy of using applied learning projects.

Participant expectations and understanding of the program

At the beginning of the program year, many participants had a limited understanding of the Academy’s purpose. Eleven of the 18 participants interviewed reported that they did not know what to expect from the program and seven of the 18 thought the program was designed to be project-focused.

- *“Initially I thought it was to move my coalition forward and not about my leadership skills as an individual. I was overwhelmed at first, because I didn’t understand what we had applied for. I never thought it would be like that.”*
- *“I guess I thought it would get us going on our project. I didn’t really know what to expect.”*

Once participants became engaged in the Academy’s processes through the retreat, webinars, and meetings with coaches, their understanding and acceptance of the program’s leadership learning focus improved.

This theme was also noted in the mid-term assessment, which showed that 44% of respondents (n=28) indicated that at the time of their team’s application they understood the program’s focus to be entirely or primarily focused on the community health improvement project, this percentage decreased markedly to 12% (n=8) at the mid-term assessment, where 46% of respondents (n=30) indicated a focus primarily a leadership development.

Participant satisfaction with the NLAPH Program

When asked in the follow-up survey to rate their overall satisfaction with the program, respondents (n=67) rated satisfaction with the NLAPH an average 7.96 (where 1= completely dissatisfied, and 10=completely satisfied).

- **91% of respondents** (n=67) at least somewhat **agreed** that the program model—defined as the annual retreat, webinars, coaching support and network building—was **effective and sufficient in supporting intersectoral leadership development** (with over 1/3 strongly agreeing that the model was effective and sufficient).
- **98% of respondents** (n=66) at least somewhat **agreed** that the program strategy of promoting experiential learning by **applying leadership development content to a community health improvement project was effective** (with about 2/3 strongly agreeing that this was the case).
- **97% of respondents** (n=67) at least somewhat **agreed** that they would **recommend this program to colleagues** (with 2/3 strongly agreeing).

Participant perception of contribution of NLAPH to leadership growth

The majority of participants indicated that participating in NLAPH contributed to their growth as an individual leader, their team’s development as a team, and progress on or success in their team’s project (see **Table 5**).

“The program has been extraordinarily helpful. We’ve really been able to apply the skills and resources.”

- NLAPH Participant

They also indicated that there was alignment between the NLAPH’s focus of leadership development and areas that were important to them. Over half of respondents (n=66) to the follow-up survey stated that NLAPH had **increased leadership skills and abilities that were important to them and their work “a great deal,”** with an additional 44% responding “somewhat.”

Table 5: Contribution of NLAPH to Development & Progress (n=68)

	A great deal (4)	Somewhat (3)	Very little (2)	Not at all (1)	Average rating
Your growth as an individual leader	56%	35%	9%	--	3.47
Your team's development as a team	66%	28%	6%	--	3.60
Progress on or success in your team's project	59%	37%	4%	--	3.54

When asked about which program components contributed the most to their growth as a leader, respondents rated the national retreat the highest followed by the tools and resources provided and coaching support (see **Table 6**). Network promotion was perceived to be the component that contributed the least to leadership growth.

“With our coach, our team got to a more concrete place. We took a lot of the ideas and the vehicle of the leadership group and used it to kick-start what we wanted to do. It was definitely beneficial for us.”

- NLAPH Participant

Table 6: Contribution of NLAPH Components to Leadership Development

	Agree strongly (4)	Agree somewhat (3)	Disagree somewhat (2)	Disagree strongly (1)	Avg score
National retreat (n=66)	77%	23%	--	--	3.77
Tools & resources (n=68)	41%	49%	9%	2%	3.29
Coaching support (n=68)	47%	35%	16%	2%	3.28
Reading materials (n=68)	32%	57%	9%	2%	3.21
Webinars (n=68)	27%	59%	13%	2%	3.10
Culminating Team Report (n=68)	32%	49%	16%	3%	3.10
Network Promotion (n=68)	27%	46%	19%	9%	2.90

Participant feedback suggests that the program model is effective for the development of leadership capacities, and that each component contributes to leadership growth to some extent. The next section explores the four key programmatic components—webinars, national retreat, coaching, and network promotion—in more detail and suggests opportunities for further strengthening these components.

C. Program Delivery Components

The evaluation sought to understand how each component of the NLAPH program was implemented and how it contributed to progress in leadership, intersectoral collaboration, and the community health improvement project. This section focuses on the four key components—webinars, the national retreat, coaching and network development. For each component, the evaluation assessed implementation, participant and coach satisfaction, the most valuable aspects, and opportunities for improvement. Data, to inform this analysis, was extracted from program documents, participation data, team and individual participant surveys, post-webinar and post-retreat surveys, and participant and coach interviews.

1. *Webinars*

Description of webinars

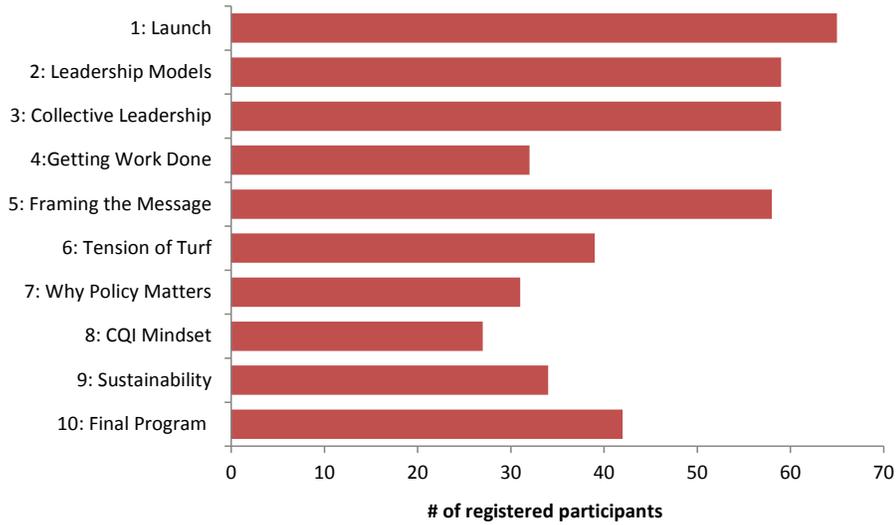
Webinars were one of the key methods by which the NLAPH curriculum was delivered to participants. Webinars were generally designed by CHLP staff and the Curriculum Hub, in conjunction with other NLAPH Advisors.

A total of ten different webinars were held for Cohort 1 participants. This includes the “launch” webinar in late February (which provided an overview of the NLAPH program itself), eight topical webinars addressing elements of the NLAPH curriculum, and a final program webinar. **Appendix E** provides an overview of the webinars, speakers, objectives and dates. Participants were also provided a list of and links to a series of elective webinars that they could attend (**Appendix F**).

For individual webinars, participation ranged from 27-65 NLAPH members, with an average of 44.6 people attending each webinar (see **Figure 3**).³ The NLAPH “launch” webinar had the highest turnout (81%, n=65). The data suggest that participation in the initial five webinars was higher than it was in the last five (average of 54.6 people as opposed to 34.6 people); however, this decrease may have also been seen because team members began watching the webinars together (see footnote).

³ Participation numbers are based on registration and attendance data; if multiple members of teams watched the webinar together, participation numbers would be higher than what is reported here.

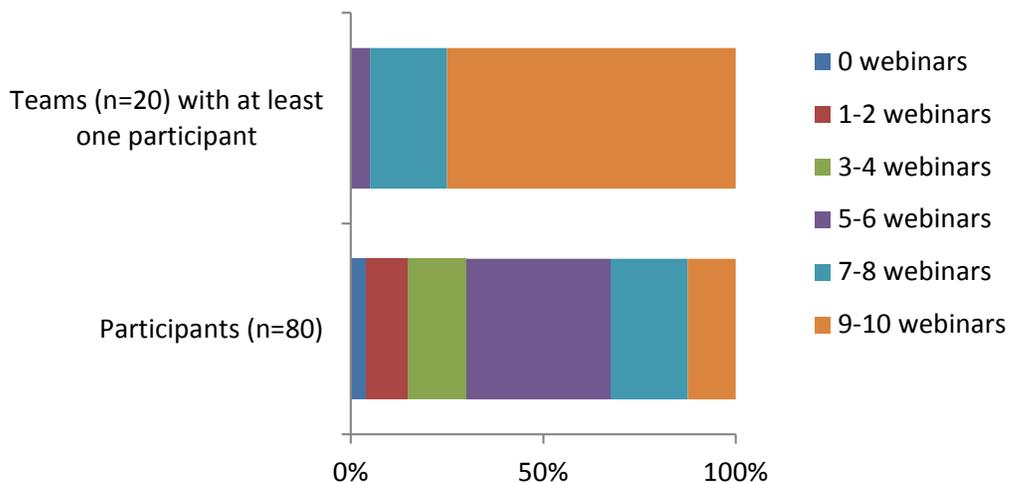
Figure 3: Webinar Participation by Session



Consistency of webinar participation

70% of individual participants attended at least 5 of the 10 webinars, with about a third of participants attending 7 or more. Of the ten core webinars, average attendance for individuals was 5.5 webinars. Teams, however, were generally well represented, having at least one participant on an average of 9.2 of the 10 webinars. Twelve teams (60%) were represented on all 10 webinars (see **Figure 4**).

Figure 4: Webinar Participation by Participants and Teams



Participant satisfaction with webinars

In the follow-up assessment, participants were asked to think about the overall value and effectiveness of the program’s webinars. Nearly all participants at least somewhat agreed that the webinars they attended were relevant to their growth as a leader, helped increase their effectiveness as a leader, and were a valuable use of time (see **Table 7**). These high levels of agreement are consistent with responses to the mid-term assessment.

Table 7: Satisfaction with Webinars (n=67)

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly
Overall, the webinars I attended were relevant to my growth as a leader	37%	55%	6%	2%
Overall, the webinars have helped to increase my effectiveness as a leader	34%	54%	8%	5%
Attending the webinars has been a valuable use of my time.	34%	55%	9%	2%

Additionally, when asked about the contribution of different components of NLAPH, the majority of respondents (n=68) agreed strongly (27%) or somewhat (59%) that the webinars contributed to their growth as a leader.

Interview responses about satisfaction with the webinars were varied. About half of those interviewed reported that the webinars were consistently valuable, while the other half said that some were more valuable than others. See **Table 8** for illustrative quotes from participants on these two perspectives.

Table 8: Illustrative Quotes—Consistent or Variable Satisfaction with Webinars

Consistently Valuable	Variability in Value
<i>“All of the webinars were good. I really liked them.”</i>	<i>“Some of the webinars were better than others. A couple were good and established our expectations, but some were not as good.”</i>
<i>“The webinars were really good.”</i>	<i>“The webinars were variable. Some of them were helpful early on to get background information on the theory of leadership.”</i>

Value of individual webinars

Given that participants reported some variability in the value of webinars, the evaluation also looked at the individual surveys that were conducted at the end of each webinar. While the interview respondents spoke of variability in usefulness, in general, the majority of respondents to the post-webinar surveys indicated that the webinars had provided them with the desired knowledge/tools as dictated by the objectives for the webinars (see **Appendix G** for a summary of responses to a sample of the key webinar objectives).

Respondents to the mid-term and follow-up surveys were asked, of the webinars they attended, whether there was one that stood out as having been most insightful.

- 73% of respondents (n=62) to the mid-term assessment responded “yes”. Of the first five webinars, the four webinars that introduced new content were all selected by at least 8 respondents as the most insightful:
 - Framing the Message (webinar 5): 16/47 (34%)
 - Leadership Models We Can Learn From/Meta-leadership (webinar 2): 14/47 (30%)
 - Community Health Improvement – Getting the Work Done (webinar 4): 9/47 (19%)
 - Collective Leadership (webinar 3): 8/47 (17%)

- 39% of respondents (n=67) to the follow-up survey responded “yes” that there was one webinar that stood out as the most insightful. Of the last five webinars, all of the webinars were selected by at least 1 respondent as the most insightful:
 - Sustainability Planning (webinar 9): 11/27 (41%)
 - Tension of Turf (webinar 6): 9/27 (33%)
 - Why Policy Matters (webinar 7): 3/27 (11%)
 - Final Program Webinar (webinar 10): 3/27 (11%)
 - Got Data – Leading with a CQI Mindset (webinar 8): 1/27 (4%)

Most valuable components of webinars

At the conclusion of each webinar, participants answered open-ended questions on the post webinar survey. Responses to these questions provide insight into webinars’ best features and areas needing improvement.

In general, participants valued webinars that included **concrete examples of leadership in practice**; incorporated **interactivity** into the format of the presentation; the **diversity and background of speakers**, and **hearing from other NLAPH teams** about their projects. (See **Table 9**.)

Table 9: Most Valuable Aspects of the Webinars

Theme	Description	Example Quotes
Concrete, practical examples	Practical, real-life examples of leadership in practice were overwhelmingly perceived to add value to the webinar series.	<ul style="list-style-type: none"> • “[The webinar was] comprehensive and facilitated the translation of theory into practice with real world examples.” • “Hearing specific examples about behavior that we can adopt to implement [was a best feature of the webinar].”
Interactivity	Webinars that were interactive in nature were perceived by many to enhance the webinar experience.	<ul style="list-style-type: none"> • “I liked the polling. They are a lot of fun and a good way to get people involved in the lecture.” • “Appreciate early call preps for utilizing Q&A, chats, hands; frameworks provided, slides, intervening chats and polls to engage audience.” • “The ability to have chat and verbal comments”
Diversity/ background of speakers	Participants attending the webinars reported that the diversity and background of speakers was greatly valued. Participants appreciated when varied points of view were offered on similar concepts.	<ul style="list-style-type: none"> • “The experience and related professional and personal knowledge of each presenter [was a best feature of the webinar].” • “Multiple presenters offering rich, concise content...”
Participation of NLAPH teams	The final webinar session where team members presented their NLAPH projects was well received by many participants.	<ul style="list-style-type: none"> • [The final webinar] “provided an opportunity for all teams to learn from each other in regards to their project, leadership, barriers. Best feature-sharing from the teams on how they overcame barriers along the way.” • “...hearing how others used the learning experiences and tools. It reminded me of what we had done, had forgotten, and could be doing.”

Opportunities for improving webinars

Although most comments on the webinars were positive, a large number of participants offered suggestions for improvement. Many participants commented that **materials should be provided in advance of webinars**; while program staff noted that materials were available on phConnect prior to the webinar, low utilization of the site (in general) and difficulties navigating it resulted in many participants not accessing these materials. Participants also suggested ways to increase **audience engagement**, and highlighted a number of **technical problems** experienced by speakers and webinar participant (see **Table 10**).

Table 10: Opportunities for Webinar Improvement

Theme	Description	Example Quotes
Provide materials in advance of the webinar	A large number of participants reported that they would like to have webinar slides, tools, and other materials in advance of the webinar for note-taking. Others requested this information to generate ideas and questions to be posed during the webinar.	<ul style="list-style-type: none"> • “Either allow us to download PowerPoint slides earlier or get a transcript; was hard to take notes going back and forth between webinar slides and Word.” • “I would like to see the distribution of presentation slides before broadcast to foster questions specific to the topics.”
More interaction & follow-up	In order to increase audience engagement, many participants expressed interest in seeing the faces of presenters and other participants. Some participants commented on wanting an audio Q&A with panelists after presentations were completed in order to foster more a more tailored experience. Finally, a number of participants suggested facilitating more opportunities to share experiences among participants related to the webinar topics.	<ul style="list-style-type: none"> • “I think the discussion feature is cool but people didn’t really participate. It might be good, as you are getting the participants warmed-up with the group, to “plant” a few comments before the webinar/calls, so that you have a couple ready to go, to inspire others to jump in.” • “...open a discussion on phConnect after each webinar for people to post tools, ideas etc.”
Address technical problems	The majority of comments for areas of improvement dealt with technological problems experienced by participants and speakers. A large number of participants expressed dealing with problems related to sound and video complications. Others commented that the group could benefit from video presentation training themselves, and that, for presenters, a technical dry-run may contribute to the flow of future webinars.	<ul style="list-style-type: none"> • “The audio and visual were disjointed. The area for me to send in questions was inactive so I couldn’t ask a question.” • “We all might benefit from video presentation training (e.g. how to project and looking at camera... lighting reminders)” • “Maybe a technical dry-run with the presenters beforehand so they better understand the software.”

2. National Retreat

Description of retreat

A couple months after the initial launch, NLAPH participants, coaches, and program staff were convened for a multi-day, in-person community health leadership retreat. The retreat was held May 6-9, 2012 in Atlanta. The event included a registration and welcome reception the first evening, followed by two-and-a-half days of sessions.

The overarching themes of the retreat reflected the NLAPH program's integrated focus on both the leadership spectrum and the prevention/policy/systems change spectrum. Broadly, the sessions addressed:

- Self-awareness and leadership reflection
- Collaborative approaches
- Systems thinking and policy change
- Prevention and health equity

Retreat attendance

Retreat attendance was very high, with 78 of 80 participants (98%) attending. Most participants were able to attend the entire retreat.

Participant satisfaction

Participant feedback immediately after the retreat was favorable; at least 90% of respondents indicated agreement (strongly or somewhat) that the retreat:

- Increased their understanding of the program (97%);
- Increased their team's collaborative capacity (96%);
- Provided skills, tools and resources for teams (98%);
- Facilitated relationships with their coach (94%); and
- Promoted reflective leadership (95%).

Almost all respondents (99%) indicated that the retreat would be at least somewhat valuable in supporting their team's efforts.

When asked about the components of the retreat, the majority of teams felt that the interaction with their own team, the breadth and depth of information presented and the overall length of the retreat were "about right." However, over half of respondents indicated that they did not have enough interaction with other teams or their coaches.

At the mid-term check-in, participants' perceptions of the retreat remained very favorable. 78% of respondents strongly agreed that attending the retreat was a valuable use of their time. Additionally, 60% expressed strong agreement that they

were using some of the skills, tools, frameworks or other resources gained at the retreat in their work.

In the follow-up assessment, at the end of participation, 77% reported that they strongly agreed that the retreat had contributed to their growth as leaders (with the remaining 23% somewhat agreeing). In comparison to other program components, the retreat received the highest rating as to which components contributed to leadership growth (see **Table 6** on page 13). Additionally, in the participant interviews, 13 of the 18 respondents specifically named the retreat as a very valuable component of the program, and six of them said that it was *the most* important component of the program.

“What I learned at the retreat has helped me in the real world. I use it in my daily work.”
- NLAPH Participant

Most valuable components of the retreat

In general, as discussed above, the retreat continued to be identified as one, if not the most valuable components of the NLAPH. When asked about the most valuable topics covered in the NLAPH, three sessions were called out in both interviews and the follow-up assessment:

- Inner-Leadership: Understanding Self and Others (MBTI presentation)
- A 21st Century Approach to Prevention: Opportunities for Improving Health & Safety and Promoting Health Equity (Larry Cohen, Prevention Institute)
- What Working with Other Sectors Means (Angela Blackwell, PolicyLink)

Participants also spoke about the value of having time to spend with their teams and face-to-face time with their coaches at the retreat. For example, one participant said: *“The opportunity to work together and spend time together in Atlanta really pulled us together as a team.”*

Opportunities for improving the retreat

Feedback throughout the NLAPH program about how the retreat could be improved remained fairly consistent. **Table 11** summarizes suggestions for how the retreat could be improved.

“I know there was some disappointment among our team that we couldn’t get together again with the other teams. We built bridges with some of the other teams, and we wish we could’ve convened again.”
- NLAPH Participant

“We didn’t spend a lot of time with our coach at the conference. I wish we’d had [more] time with [our coach] there.”
- NLAPH Participant

Table 11: Suggestions for Improving the National Retreat

	Post-retreat survey	Mid-term assessment	Post-NLAPH Interviews
Make days less dense—suggestions varied: add an additional day, make presentations shorter, add another retreat, cover some material in webinars	X		
More time for networking and interaction with other teams	X	X	X
More time for teams to spend with coaches	X	X	X
Adding an additional retreat (later in the program year)	X	X	X
More practical information and tools		X	
Holding the initial retreat earlier in the program year			X
Less time on ice breakers & games			X

For more detailed information about the retreat, refer to the mid-term evaluation report.

3. Coaching

As noted earlier, coaching support to the participating teams was a key component of the NLAPH program model. Coaches helped the teams apply a leadership frame to their applied community health projects. In the pilot year, there were eight NLAPH coaches.

Coach matching and training/support received

The coach assignment process took place in March and April 2012. The matching process was based on a combination of team- and coach-specific factors (for details about this process please refer to the mid-term evaluation report). The coaches were assigned to between 2 and 4 teams, with the majority of coaches (n=5) working with two teams. The majority of coaches and team leads indicated that the coach was a good match for the teams (see **Table 12**).

Table 12: Level of Agreement that Coaches and Teams are Well-Matched

	Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly
Coaches (n=8)	75%	25%	--	--
Team leads (n=16)	56%	25%	19%	--

The coaches received initial training and ongoing support from the CHLP program office. Training and support included:

- Training on Action Learning and creating team synergy (training session and toolkit/workbooks were provided)
- NLAPH webinars (open to coach participation)
- Monthly coaches meetings to provide updates to the coaches, hear about progress with teams, discuss and problem solve challenges, and identify opportunities for coaches to connect with teams working on similar issues
- Forms, templates and guidelines, including: monthly call protocol, site visit guidance, sample Memorandum of Understanding (MOU) for the coach to use with teams, and site visit report form
- Administrative support for travel arrangements and contracting

At the mid-term assessment, coaches indicated being somewhat (63%) or very (38%) satisfied with the support received. The area of greatest concern to coaches in regard to their training and support was their incomplete understanding of the 'emergent' NLAPH curriculum (with 50% disagreeing that they understood the curriculum). A few coaches also felt that the coach training was somewhat inadequate.

Coach services to teams

The national retreat provided the first opportunity for coaches to meet with their teams. Coaches were instructed to sit with their teams during sessions and exercises, splitting time between multiple teams as needed. Most coaches and participants valued the opportunity to meet in-person, however, the majority of both coaches and participants indicated that they did not have sufficient time at the retreat to spend together (75% of coaches (n=8); 52% of participants (n=63)). For more information on feedback about team-coach interaction during the retreat, please see the mid-term evaluation report.

Following the national retreat, coaches were to begin their regular, ongoing coaching work with teams through monthly team coaching calls. A team lead was appointed to serve as the liaison for coach-team communications and scheduling.

- **Role of the team lead:** At the mid-term assessment, coaches agreed that using team leads worked well in facilitating the delivery of coaching to teams. In general, coaches described the majority of team leads that they worked with as ambitious and hardworking. While several coaches noted that they had more contact with the team lead than with other members, they also indicated that the time they had to interact with the team leads may not be sufficient. Team leads generally agreed that they had received more help and attention from the coach than their teammates did. However, they also reported that they spent

more time than their teammates doing NLAPH work and felt more responsibility for progress. Example quotes from team leads include:

- *“It was more work for me. I would talk with our coach before our team meetings, put together the agenda, facilitate the calls, and do any follow-up. It just ended up being a bunch more work for me.”*
- *“I had more interaction with our coach. I benefitted from that. Just seeing how he worked and his thoughts on challenges in the project.”*
- **Monthly coaching calls:** The focus of the monthly coaching calls varied based on the needs of specific teams and the skills and expertise of coaches. At the mid-term assessment, coaches were asked to estimate the time they spent with their teams on general areas. On average the greatest amount of time was spent on leadership learning (an estimated at 25% of time with teams; ranging from 15-40% depending on the team), followed closely by project-related technical assistance (22% of time with teams). Other topics of focus included (in order of time spent): team development, intersectoral collaboration, and basic management skills (e.g., meeting preparation). These results are discussed in more detail in the mid-term evaluation report.
- **Site Visits:** Each team was to receive a single site visit from their coach during the program year. This was added after the retreat because of the interest in face-to-face time. 15 site visits were completed by the target of August 31, 2012; the remaining five were conducted by the end of the program year. There was wide variation in the length and frequency of the site visit, with site visits ranging from 2 hours to 2 days, and at least one team received two site visits. Coaches indicated that the site visit was an essential element in developing successful team/coach relationships—it helped to facilitate relationship building, allowed coaches to better understand team dynamics and the context in which teams work, and helped teams expand their thinking about participation in NLAPH and their project. The majority of team leads agreed that the site visit was an essential element in promoting a successful coach relationship (13/16). Because of the benefits of face-to-face time with the teams, 7/8 of the coaches indicated that one site visit was not adequate; however, the costs associated with conducting the site visit and difficulties scheduling may preclude conducting more than one. The coaches’ experiences with site visits are discussed in more detail in the mid-term report.

Coach satisfaction with coaching experience

Coaches were generally satisfied with the NLAPH coaching experience. At the mid-term assessment, 75% of coaches indicated they were very likely to coach again in a subsequent cohort if they were asked, and the other 25% indicate they were somewhat likely. Seven of the eight coaches did continue to participate as coaches for Cohort 2, which began in February 2013.

Team satisfaction with coaching contribution

During the mid-term assessment, the majority of team leads (81%, 13/16) agreed that the coaching model—defined as in-person meetings at the retreat, monthly calls, and 1 site visit—effectively supported their team.

The majority of teams (n=19), in the follow-up assessment, indicated that the coach was at least somewhat instrumental in advancing the leadership capacity and effectiveness of their team (37% said “a great deal”, 47% said “somewhat”). Three teams indicated that the coach had contributed very little to their leadership capacity and team effectiveness. Looking at the distribution of team ratings across coaches, 7/8 coaches had an average rating of between 3.0-3.7 across their teams (on a scale of 1-4, with 1=“not at all” and 4=“a great deal”); one coach received a “very little” contribution rating from both teams.

Individuals also rated the extent to which the coach had contributed to their individual growth as a leader. Almost half of respondents strongly agreed that their coach had contributed to their growth as a leader (47%); another 35% agreed somewhat (n=68).

Most valuable components of coaching

From the participants’ experience, face-to-face time with the coaches, both at the retreat and site visit, was perceived to be very beneficial. Example quotes from participants include:

- *“I think, overall, for us, the most valuable thing was talking to our mentor. Once we met with [the coach] in person, it all started to click. The mentorship for us was really helpful and went above and beyond what we were expecting.”*
- *“I think the biggest thing I took away was coaching. [Our coach’s] perspective brought a lot to our experience. He really helped us see how we were developing as leaders in our community.”*

Coaches talked about various aspects of their approach to coaching that worked well, these components included:

- The importance of **supporting individual leadership skills** in addition to working with the team as a whole (7/8); three coaches reported that providing individual guidance helped to improve overall team performance.

“The magic of the Academy is in the coaching. The coach gets opportunities to be the sense-maker for the group. If they’re getting things well, you can accelerate them. The coach is the moderator and helps make it an applied experience.”

- NLAPH Coach

- Providing **technical assistance for the teams’ projects** to help them move forward (7/8); many noted that they spent more time on this than anticipated given the Academy’s focus on leadership learning. Many coaches were

“Early on I figured out how to craft an argument that the projects were important; that they were an important vehicle through which to work on improved leadership skills. So I immediately integrated the two (project and leadership).”

- NLAPH Coach

involved in helping teams refine the scope or direction of their project. The project specific technical assistance helped coaches build credibility to support the teams in leadership learning and discuss curriculum examples using practical examples.

- The coaching model—a **team-based approach**—was perceived to be effective and appropriate (6/8): *“I think it’s easier to do leadership coaching for a team, because each person, in real time, is being perceived by others around them and having to be accountable to each other.”*
- The **need to adapt** coaching services to the needs of each team (4/8)

“My teams trusted me. I didn’t have to struggle with them. They felt I had a lot of experience. I also made a decision to be of service to them early on; that reinforced the trust, and the sense that I was relevant.”

- NLAPH Coach

Coaches identified many successes in working with their teams related to both the project and leadership development. In terms of projects, coaches played a key role in helping teams better define their applied community health improvement projects. Two of the coaches noted successful efforts to help teams re-scale their projects (e.g., downsizing to better leverage available resources and create a more replicable model), and another two noted they were able to help teams clarify their project goals, strategies and activities (discussed further in the section on project progress in NLAPH

“There was one moment I’m proud of...A structural health inequity issue was coming up, and the team couldn’t articulate it. I was able to see it and engage them productively.”

- NLAPH Coach

Outcomes). Coaches also noted many successes in the area of leadership, examples are provided in a section on leadership development in NLAPH Outcomes.

Challenges and opportunities for improving coaching

The key challenge reported by both coaches and team leads was scheduling times to meet. Team members were busy and it was difficult to find time that worked for all members and the coach. Coaches and team leads also expressed that it would have been beneficial to have more time together—particularly in-person. One participant stated, *“I really liked our coach. We only met with him once after the retreat. I wish we had been able to meet with him more.”*

Relationship-building issues were noted by several team leads in the first half of the program. One team noted they had initially felt disconnected from their coach, but they were later able to have an honest dialogue with the coach and clarify the miscommunication. Reflections from other team leads include:

- *“New teams sometimes require delicate and balanced interactions, and the involvement of the coach in these situations needs to be very sensitive.”*
- *“It takes time to get to know your coach and figure out what he/she can offer. The coaches aren't necessarily leadership trainers - they are people who have experience in leadership, which is different.”*

In the follow-up interviews, a couple of teams (n=2) and their coaches (n=2) acknowledged that they were not particularly well matched in terms of style and personalities, and that created challenges in benefiting from the relationship. For example, one participant said *““It was interesting to learn that our coach didn't really understand our learning level and where we were coming from.”*

Other challenges that coaches mentioned included:

- Initial lack of commitment to leadership learning among some team members, who were interested in focusing more on the project: *“I had to spend considerable time at the site visit reviewing the purpose of the Leadership Academy and the coaching function, and convincing them of the potential value to them of organizing themselves into a leadership learning community and focusing on leadership challenges.”*
- Lack of time and funding to provide the additional assistance that would benefit the team and/or individuals, particularly when challenges arose.
- Variation in coaching styles and approach; recommending that a more standardized approach to coach training and preparation may be valuable.

- Difficulties reinforcing the emerging curriculum through coaching calls due to uncertainty about the curriculum and the timing of some sessions not aligning with team needs
- Balancing direct coaching time with other NLAPH responsibilities, for example:
 - *“We ended up constantly being consulted on administrative issues like feedback on curriculum, feedback on retreat, and the competencies. Coaches were used as a resource for the program, but it undermined our time to focus on the teams.”*
 - *“Coaches were busy with a lot of other things...preparing for the retreat, launching, putting the curriculum in place.”*

4. Network Development

As noted in the overall program description, network development was another important piece of the NLAPH model. When compared to other components in the NLAPH program model, participants—on average—rated the contribution of network promotion to their leadership growth the lowest of all components (see **Table 6** on page 13), with 28% of respondents disagreeing that this component contributed to leadership growth.

phConnect

One of the primary strategies for promoting expanded networks—beyond the intersectoral work of the teams’ applied community health improvement projects—was via the NLAPH pages on phConnect. phConnect is an online collaboration platform designed to support geographically dispersed professionals by providing an environment for collaborative work and professional networking. phConnect also served as a resource library from which participants can access old webinars, download copies of presentations and related resources, and access core NLAPH program documents. Overall, program staff found phConnect to be limited in its functions for the NLAPH program.

There were 109 members of the NLAPH page on phConnect, including all 80 participants. Program staff, coaches, consultants and CDC representatives were also members of the page.

Each of the twenty participating teams has a team page on phConnect. These pages provided a simple description of the teams’ project, and allowed space for the teams and their peers in the NLAPH program to post information, comments, updates, etc.

Throughout the program year, utilization of the team pages for peer networking was low. Of the twenty teams, only six of the team pages showed activity. Four of the

teams posted “big picture” information about their projects (i.e., stakeholders, context, vision, pathway to change, and/or critical leadership challenges). Another team posted an update, one a request for information, one team used it for team discussion related to planning, and one posted photos of the team. A majority of the activity was early in the program (March-May), with one posting each in July and August. There were no additional postings after August 2012 to any of the team pages.

The NLAPH home page on phConnect also included a place for discussions and comments. Online discussion was limited, with only three discussions posted to the community’s main page. All three conversations were initiated by CHLP staff. The “Comment Wall” also on the main page, had three postings, all of which were in response to the retreat.

phConnect also provided the archived webinars, list of elective webinars, and other relevant documents and articles.

National network development

Beyond phConnect, there were opportunities for teams to connect at the retreat and through webinars. Additionally, coaches and program staff connected teams with other NLAPH teams and experts working on similar issues.

As a result of this work, Cohort 1 participants reported modest growth in their *national professional network*; about a third of respondents (n=68) reported at least moderate growth to the **size** (33.8%) and **strength** (35.3%) of their national professional network. Interview data indicated that participants’ access to their NLAPH coaches’ networks played an important role in the growth of their national professional networks. Participants also credited contact with other NLAPH teams at the national retreat for national network growth. Some comments from participants included:

- *“Our networks developed just through working with our coach. She gave us contacts and connections.”*
- *“At the conference we made a lot of great connections and we found sharing with them really helpful. We ended up doing some meetings toward the end where a few teams who were working on similar things were able to get together and share what was going on.”*
- *“From the Academy, there were two other preparedness groups, and we’ve seen each other since...and it’s good to connect with them and bounce ideas off of each other.”*

Several participants who were interviewed said they would have liked more opportunities to connect with people from other NLAPH teams. Participants indicated that there was not enough time at the retreat to connect with other NLAPH team members. They also expressed regret that there was not an additional retreat or in-

person opportunity later in the program year. In the post-participation survey (n=68), 69% of respondents reported developing new professional relationships with other NLAPH participants “very little” or “not at all.” Example quotes from participants include:

- *“I would have liked more opportunity to network in Atlanta.”*
- *“Going to Atlanta, we had big hopes of learning from other teams, but we really didn’t get the opportunity to learn from, or really even interact with them.”*
- *“I know there was some disappointment among our team that we couldn’t get together again with the other teams. We built bridges with some of the other teams, and we wish we could’ve convened again.”*

Local network development

The requirement that NLAPH participants work in local intersectoral teams intended to increase local professional networks. In the individual follow-up assessment (n=68), over 80% of respondents indicated that NLAPH contributed to at least moderate growth of the **size** and **strength** of their *local professional network*. Interview data from a sample of Cohort 1 participants (n=18) indicated that the most significant factors contributing to the growth in size and strength of local professional networks were the exposure to their teammates’ existing networks and their project-related outreach to sectors and organizations they had not previously engaged.

In the team follow-up assessment (n=19)—in which they formed and submitted consensus answers to a series of questions—63% of teams (12/19) reported that they had successfully leveraged the individual networks of team members to advance their projects. Illustrative participant comments regarding local network development include:

- *“Because we didn’t really know each other, our networks expanded just by working together.”*
- *“We met with other agencies and community members and it expanded my network. A lot of that came from my relationship with my teammates.”*

III. NLAPH Outcomes

The evaluation sought to understand the outcomes associated with NLAPH participation in the short-term (i.e., immediately following the completion of the program). This section provides a summary of the results associated with the outcomes of interest, which included: leadership development, improved intersectoral collaboration/team development, and progress on the applied health learning project. This analysis was based on baseline, mid-term, and follow-up assessments (at both the individual and team level), coach assessments of team progress, and participant and coach interviews.

A. Leadership Development

In the follow-up individual assessment (n=68), the majority of respondents indicated that the NLAPH contributed to their growth as a leader “at least somewhat,” with 56% saying that it contributed “a great deal”. In the follow-up team assessment (n=19), almost 75% of teams reported that they made more progress in leadership than they expected. Teams also reported “fair” to “good progress” on the leadership learning goals they articulated for themselves (rated on average 3.87, on a scale of 1-5, with 3=“fair progress” and 4=“good progress”) (see Appendix H for more details).

1. Individual Leadership Competency Development – Pre/post comparison

Results from participants’ self-reported abilities for each competency, at baseline and follow-up, showed statistically significant improvement on all 23 competencies across the four competency domains—Individual Leadership Mastery, Ability to Work Across Sectors, Appropriate Use of Data, and Commitment to a Public Health Perspective—for which pre/post data were available (See **Table 13**). *(Note: there were no pre/post measures for the fifth domain regarding Continuous Quality Improvement because it was added as a competency domain after the baseline assessment was conducted.)*

While there were significant improvements in all competencies, the items for which the **change was greatest** in each domain (i.e., largest change in the mean score from baseline to follow-up) are as follows:

- Individual Leadership Mastery: (8 items) The mean difference was the greatest for the ability to **build and sustain trust among team members and partner agencies** (diff: 0.53).
- Ability to Work Across Sectors: (5 items) The mean difference for the ability to **understand and use community engagement strategies** (diff: 0.67) yielded the great difference from baseline to follow-up.

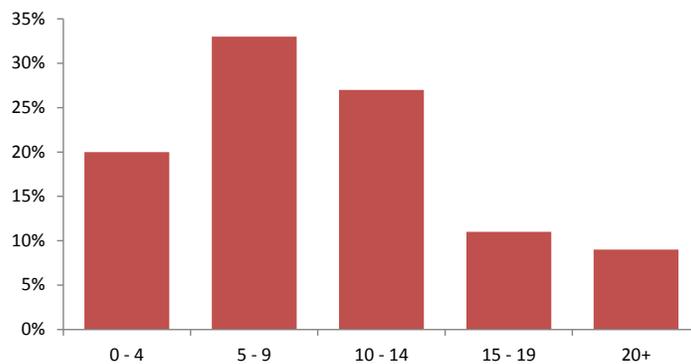
Table 13: Pre/Post Changes in Self-Reported Abilities (Individual Items)

Domain	Survey item – Abilities rated (4=very high, 1=very low)	PRE Mean	POST Mean	Mean Difference	Level of significance
Individual Leadership Mastery	To exercise effective leadership within an agency or organization	3.05	3.35	0.30	p≤0.001
Individual Leadership Mastery	To build and sustain trust among team members and partner agencies	3.05	3.58	0.53	p≤0.001
Individual Leadership Mastery	To build an effective team	3.00	3.40	0.40	p≤0.001
Individual Leadership Mastery	To create a shared vision and goals for teamwork	2.95	3.45	0.50	p≤0.001
Individual Leadership Mastery	To utilize effective decision-making processes	2.94	3.29	0.35	p≤0.001
Individual Leadership Mastery	To assess interests of key stakeholder	2.81	3.30	0.49	p≤0.001
Individual Leadership Mastery	To see “the big picture”	3.33	3.59	0.26	p≤0.001
Individual Leadership Mastery	To utilize knowledge of “the context” to shape project goals	2.91	3.38	0.47	p≤0.001
Effectively Work Across Sectors	To work with partners outside your own sector	3.11	3.55	0.44	p≤0.001
Effectively Work Across Sectors	To identify key stakeholders	3.06	3.48	0.42	p≤0.001
Effectively Work Across Sectors	To understand and use community engagement strategies	2.53	3.20	0.67	p≤0.001
Effectively Work Across Sectors	To work with ethnically and racially diverse communities	2.97	3.35	0.38	p≤0.001
Effectively Work Across Sectors	To engage community-based organizations and leaders in community health projects	2.77	3.20	0.43	p≤0.001
Appropriately Use Data	To identify evidence-based strategies	2.89	3.31	0.42	p≤0.001
Appropriately Use Data	To identify indicators of progress	2.72	3.20	0.48	p≤0.001
Appropriately Use Data	To use quantitative data to help develop plans and make decisions	2.69	3.25	0.56	p≤0.001
Appropriately Use Data	To assess and prioritize community health needs and assets	2.73	3.25	0.52	p≤0.001
Appropriately Use Data	To use evidence based best practices to promote systems or policy change	2.91	3.34	0.43	p≤0.001
Appropriately Use Data	To evaluate and communicate project outcomes	2.89	3.31	0.42	p≤0.001
Public Health Perspective	To obtain political support for your projects	2.22	3.08	0.86	p≤0.001
Public Health Perspective	To lead in politically charged environments	2.34	3.00	0.66	p≤0.001
Public Health Perspective	To understand the legislative process	2.62	3.09	0.47	p≤0.001
Public Health Perspective	To influence policy	2.44	3.02	0.58	p≤0.001

- Appropriate Use of Data: (5 items) Participants’ ability to **use quantitative data to help develop plans and make decisions** showed the largest difference from the beginning to the end of the program period (diff: 0.56).
- Public Health Perspective: (4 items) Participants demonstrated the greatest improvement in their ability to **obtain political support for projects** (diff: 0.86).

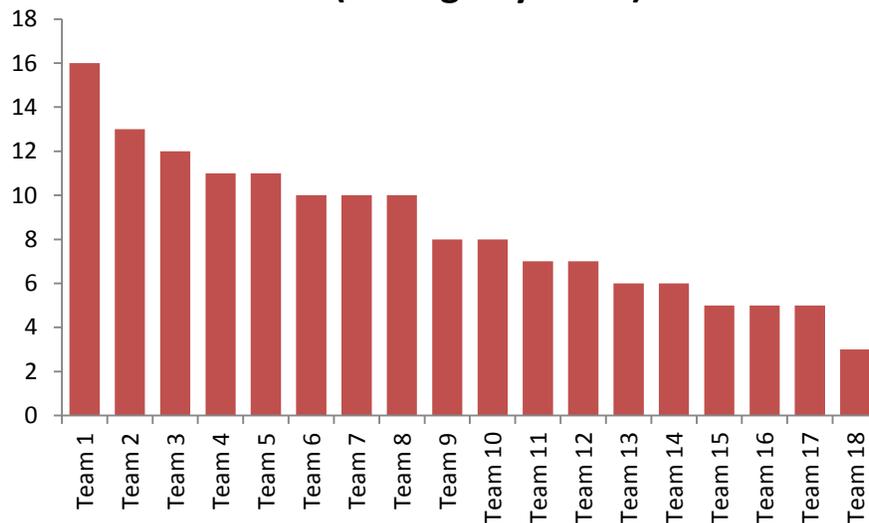
The significant improvements reported across the cohort were distributed across participants (i.e., almost all participants reported increased abilities in at least some competency areas). On average, individual NLAPH participants improved in 8.5 out of 23 competencies with a range of improvements in 0-21 competencies (see **Figure 5**).

Figure 5: Number of Competencies Improved (pre/post) by % of Participants



When looking at the distribution of individuals across teams, the average number of competencies improved within a team ranged from 3 to 16 (see **Figure 6**).

Figure 6: # of Competencies Improved (average by team)



While there were teams that collectively increased more significantly and some where little improvement was detected, there was typically wide variation in the number of competencies in which team members reported improving. This suggests that certain individuals on teams may have been more successful at developing leadership competencies than others. The variation can be seen in the ranges presented in **Appendix I**.

When looking at the competencies by the “domain,” data indicate that a majority (60%) of participants improved in three or four leadership domains, while 16% of participants improved in only one or two domains, and 24% showed no improvement in any domain. The highest percentage of participants showed improvements in the “Ability to Work Across Sectors,” followed by “Individual Leadership Mastery” (see **Table 14**).

Table 14: Improvement in Competencies by Competency Domain*

(*improvement measured by pre/post assessment of whether participants showed improvement in at least one competency related to this domain)

Competency Domain	% participants with improved abilities in each domain
Individual Leadership Mastery	71%
Ability to Work Across Sectors	73%
Appropriate Use of Data	60%
Commitment to a Public Health Perspective	69%

When asked to rate the extent to which participation in the NLAPH strengthened their skills and abilities related to each domain, the majority of respondents indicated that it had strengthened their leadership practices in each area. About half of respondents indicated that the NLAPH had increased their leadership practices in three of the domains—Individual Leadership Mastery, Working Across Sectors, and Commitment to a Public Health Practice—“a great deal” (see **Table 15**).

Table 15: Self-Reported Improvement in Competency Domain

Competency Domain	Strengthened leadership practice in each domain (self-reported rating, n=68)	
	% “A great deal”	% “Somewhat”
Individual Leadership Mastery	50%	44%
Ability to Work Across Sectors	52%	43%
Application of CQI Principles	22%	62%
Appropriate Use of Data	22%	56%
Commitment to a Public Health Perspective	47%	47%

To explore what characteristics might explain the individual variation in improvement, the evaluation assessed whether certain background characteristics of participants were predictive of more significant improvement in the identified competencies. Variables included in these analyses included: whether the participant was the team lead or not, their number of years of experience in current sector, their self-rated level of leadership, and whether they worked in public health or another discipline. The only statistically significant difference detected was that participants who identified public health as their discipline were more likely to report improved abilities related to the 'Ability to Work Across Sectors' and 'Commitment to a Public Health Perspective' domains.

2. Individual Leadership Competency Development – Post-only indicators

During the strategic planning process in June 2012, the NLAPH's Knowledge, Attitudes and Practices (KAPs) were revised. As a result a number of items included in the baseline assessment were eliminated and new items were added to reflect the important elements in the competency domains. Because these were added after the baseline assessment for Cohort 1 was complete, data are only available from the follow-up assessment.

Items were added to assess: (1) current abilities (20 new items, **Table 16**); these were structured similarly to the pre/post indicators discussed above, however, the 4-point scale used for rating was changed to try to elicit more variation in responses;⁴ (2) agreement on NLAPH values or understanding of key concepts (6 items, **Table 17**).

Across all domains, the areas where participants rated their current abilities the highest were all related to Individual Leadership Mastery, specifically:

- To demonstrate integrity and act ethically in dealings with others (3.62)
- To effectively promote communication channels (3.25)
- To effectively utilize the skills and abilities of team members (3.23)
- To engage others in meaningful dialogue on important issues (3.22)

⁴ The former scale—used for the pre/post assessment discussed above—was 4=very high, 3=somewhat high, 2=somewhat low, 1=very low. The new scale, to be used going forward, was 4=outstanding, 3=very good, 2=adequate, 1=needs improvement. As a result, the mean scores for the post-only indicators cannot be compared to the mean scores for the pre/post indicators discussed in the previous section.

Table 16: Post-only Ratings for Indicators related to Current Abilities

	Sub-competency area	Survey item—Abilities Rated (<i>outstanding, very good, adequate, needs improvement</i>)	Mean response	% very good or outstanding
Individual Leadership Mastery	Self-awareness	To leverage awareness of ones own styles strengths and weaknesses for effective work with others	3.10	88%
	Self-awareness	To effectively utilize the skills and abilities of team members	3.23	93%
	Builds trust	To demonstrate integrity and act ethically in dealings with others	3.62	100%
	Communicates effectively	To effectively promote communication channels	3.25	93%
	Communicates effectively	To frame messages effectively for different audiences	3.16	88%
	Communicates effectively	To engage others in meaningful dialogue on important issues	3.22	94%
	Builds teams	To employ strong project management skills	3.01	78%
	Builds teams	To identify and obtain external resources/expertise when needed	3.13	86%
	Manages change and conflicts	To effectively use conflict management techniques	2.86	71%
	Manages change and conflicts	To identify community change strategies	2.70	67%
	Manages change and conflicts	To lead others in implementing community change	2.84	78%
Work Across Sectors	Builds networks	To assess and strategically develop networks	3.00	82%
	Builds networks	To facilitate linkages between organizations/movements with shared goals	3.13	88%
	Engages community & diverse stakeholders	To adapt practices based on cultural context	2.93	78%
	Values collective impact	To promote sharing of talent, resources and rewards in collaborative ventures	3.14	86%
CQI Principles	Seeks and applies learning	To utilize reflection and feedback to support continuous quality improvement.	3.06	81%
	Seeks and applies learning	To appropriately adjust course based on new data	3.15	90%
Use of Data	Gathers, collects, and utilizes high quality data	To obtain and collect high quality data.	2.81	74%
Public Health Perspective	Aware of and committed to SDoH, HiAP, and Health Equity	To address social determinants of health through your approach to community health improvement	2.99	78%
	Aware of and committed to SDoH, HiAP, and Health Equity	To promote health equity	2.99	78%

Across all domains, the areas where participants rated their current abilities the lowest were all related to Individual Leadership Mastery, specifically the Managing Change and Conflict sub-competency area:

- To identify community change strategies (2.70)
- To lead others in implementing community change (2.84)
- To effectively use conflict management techniques (2.86)

Other areas rated relatively lowly included the ability to adapt practices to cultural contexts (2.91) and the two items related to awareness of and commitment to Social Determinants of Health (SDoH), Health in All Policies (HiAP), and Health Equity (both rated 2.99).

For all of the items added about NLAPH values and understanding key concepts, the level of agreement was high (see **Table 17**). There was 100% agreement for 4/6 items, with between 78-97% strongly agreeing with each statement. The two items for which there was some disagreement were:

- I value taking time during work to reflect on what I have learned (4% of respondents disagreeing somewhat)
- I understand the “Health in All Policies” concept (18% of respondents disagreeing somewhat)

Table 17: Post-only Ratings for Indicators related to Values/Understanding

Sub-competency area	Survey item—Agreement with statement (<i>strongly agree, somewhat agree, somewhat disagree, strongly disagree</i>)	Mean response	% strongly agree
Individual Leadership Mastery	Self awareness is an important aspect of leadership	3.97	97%
Work Across Sectors	Promotion of the community voice is important in effecting change	3.88	88%
	I believe in the value of collective approaches for achieving meaningful and sustainable impact	3.84	84%
	I allow others to take the lead when appropriate	3.78	78%
CQI Principles	I value taking time during work to reflect on what I have learned	3.65	69%
Public Health Perspective	I understand the “Health in All Policies” concept	3.34	52%

3. Participant Examples of Leadership Learning

Almost all respondents (94%, n=68) indicated that at the end of the program they have at least “somewhat” been able to apply new skills or knowledge acquired through NLAPH to their individual work, with 41% reporting that they have already been able to apply learnings “a great deal” to their work. An even higher percentage of respondents (99%) reported being confident that they will be able to apply the skills and knowledge learned to their work in the future.

In the mid-term assessment, 13 respondents gave examples related to individual growth as leaders. **Increased self-awareness, increased awareness of others’ perspectives, and improved communication and framing of messages** were noted by several respondents. Other individual respondents noted changes in their thinking or approach, such as being more realistic or taking time for reflection. Examples of successes reported by individuals included:

- *“I have learned the importance of influencing in all directions, which also means influencing above. I have applied this understanding to create a policy change.”*
- *“I am entering every meeting with the intent to have my mind changed and it is opening doors I had previously overlooked.”*
- *“A more sensitive awareness of the perspectives and motivations of others and an increased awareness of how to frame/view current issues to provide for broader community partner inclusion in effecting lasting solutions.”*

In the follow-up assessment, 32 respondents shared key leadership skills or capacities they developed through the NLAPH. Key themes from those examples included:

- **A sense of personal responsibility for leadership** (n=7). This was driven in part by NLAPH’s contribution to their understanding of personal leadership styles and assessing personal capabilities and processes they currently used as leaders. Participants also talked about improved understanding areas for personal leadership growth; particularly how they worked and communicated with those around them.
- **Improved communication and listening skills** (n=7). *“Communication through listening, all voices have something to offer and a better outcome is achieved if all points are taken into consideration. Be open to what may develop instead of having a preconceived idea. When working with a group, make sure you start with the same understanding.”*

“During the course of the year I developed a sense of personal responsibility for leadership. I realized that each of us are examples to others in everything we do and say and that each one of our actions has impact, can influence and are connected to a larger picture. I realized through the project that it is our responsibility to lead and influence for change and the betterment of society.”

- NLAPH Participant

- **Increased understanding of the value of and capacity to engage in intersectoral work (n=7).** This was broadly described in terms of the importance of engaging stakeholders (n=6) from different sectors in work, through effective messaging and clear communication.
- **Increased ability to work effectively in a team (n=6).** *“I learned that all team partners are important to the end results and if one team member in an integral lead role is not effectively engaged, that the entire team and the team’s goals suffer.”*

“[NLAPH made me] appreciate the importance of engaging community, state, and political leaders in moving forward health agendas. [It also] Increased my sensitivity [to recognizing] others’ strengths and areas of interest and utilizing them appropriately.”

- NLAPH Participant

In interviews, 17 of 18 participants reported individual growth as a direct result of Academy participation. Examples included increased **capacity for collaboration, leading without formal authority, more comfort taking the lead, stronger skills, and better systems thinking.** A few examples include:

- *“I would say that it really changed my approach professionally in my day to day job in terms of partnerships and collaborating with other sectors; to think cross-sectorally every day.”*
- *“For me, it reaffirmed and reinforced the concept that leadership doesn’t mean you have to have formal authority. You can just lead and provide leadership. The collaboration multiplier was a great tool that we got. It provided a really practical way to do that.”*

Teams were asked to report on leadership progress as part of their Culminating Reports, presented and submitted in January-February 2013. A summary of the Culminating Reports can be found in **Appendix J.**

4. Coach Assessment of Team Leadership Progress

Coaches were asked to rate their teams’ progress in leadership learning as part of the mid-term and follow-up assessment. At mid-term, half of the teams were seen to be making expected levels of progress in leadership and half were not. At the end of the program, coaches indicated that 17/19 teams made expected levels of progress (see **Table 18**).

Table 18: Coach Assessment of Team Progress

Teams are making expected levels of progress in leadership	#/% of teams	
	Mid-term (n=20)	Follow-up (n=19)
Strongly Agree	4 (20%)	9 (47%)
Somewhat Agree	6 (30%)	8 (42%)
Somewhat Disagree	8 (40%)	1 (5%)
Strongly Disagree	2 (10%)	1 (5%)

When asked what factors influenced team’s progress, coaches indicated that initially many teams were slow to organize, become a collaborative team, and adopt specific leadership goals. Successful teams were seen as having been able to establish stakeholder relations, leveraged team member skills and strengths, and adopted project and leadership goals.

In assessments and interviews, coaches cited examples of successes in collaborative leadership. A few examples of successes included:

- *“One of the most valuable areas of progress has been assembling all of the appropriate sectors within the community to develop their project. The NLAPH has served as the impetus to bring [stakeholders] together.”*
- *“They have done a tremendous job in utilizing an array of resources and models to further their leadership capabilities, and have identified and engaged community partners to address their chosen topic.”*
- *“The team members are actively engaged and seemed to really value the information shared and the skill-building aspects of the leadership retreat in Atlanta. They had very substantive discussions about how they would follow-up the retreat with active work as a team on both their community project and the leadership development and active learning objectives.”*
- *“I could see individuals benefitting from involvement in the process; teams benefitting in terms of their effectiveness in working together and being strategic..., and helping individuals and teams be effective working in an intersectoral environment.”*
- *“I saw...teams working more effectively and better together, and also exerting some leadership skills and capacities that would help the broader collaboration or communities they were working in.”*
- *“Regarding my teams, I saw them accomplish more than I thought, both in terms of growth in leadership mastery and by what they were able to accomplish...The leaders really led, did a lot of cross-boundary work, and they really became a team.”*

B. Team Development/Intersectoral Collaboration

In the follow-up individual assessment, the majority of respondents indicated that the NLAPH had contributed to their team’s development as a team at least somewhat, with 66% saying that it contributed “a great deal” (n=68).

1. Team Readiness & Engagement

Team readiness

While coaches agreed that nearly all the teams seemed to be good candidates for the program (18/19), there was less agreement that teams were actually “ready” to participate effectively. One quarter of all teams within the Academy (25%, n=5) were judged by coaches to be insufficiently ready to effectively participate. Coach comments suggest the reasons for this discrepancy between apparent fit and actual readiness may reflect a range of leadership and/or project related factors, such as a misunderstanding of the intent of the NLAPH program, inadequate technical capacity to take on the intended project, or the absence of critical stakeholders. As one coach stated in the follow-up interview: *“We’ve all discussed before how many of the teams—through the selection process or through creation of first impressions of what this program is—clearly a lot of members didn’t understand what the Academy was or was not.”*

In their mid-term assessments, coaches identified factors that they felt contributed to the team’s readiness—or lack thereof. In general the factors contributing to readiness were mentioned across many teams (5-9 teams), whereas the factors contributing to teams not being ready were only mentioned as factors for one or two teams (see **Table 19**).

Table 19: Factors contributing to team readiness

Factors contributing to team readiness	Factors contributing to a team not being “ready”
<ul style="list-style-type: none"> • Team was well situated in the community/community efforts • Team members were enthusiastic/committed • The team had a strong background in public health and/or relevant content expertise • The team had previously established working relationships • The team had a strong, committed leader 	<ul style="list-style-type: none"> • Weak coalition/collaborative effort • Politically charged environment/unwillingness of key stakeholders to participate • Funding cuts for the project • Limited understanding of the purpose of NLAPH • Limited exposure to applied public health prevention methods • Historical conflict between team members

Team “readiness” seemed to have been an important factor in determining whether a team was engaged in the Academy and made progress in leadership and/or their community health improvement project. For four of the five teams that were considered to lack sufficient readiness at the beginning of the program, coaches also disagreed that they were highly engaged in the program, that they had made expected progress on their project, or that they had made expected progress in leadership.

Team engagement

Based on their initial work with teams, coaches were asked to rate each team’s level of engagement in the Academy at mid-term. For the majority of teams, coaches only somewhat agreed that they were highly engaged (55%, n=11). For most of the other 40% of teams (n=8) coaches disagreed that they had a high level of engagement. Only one team (5%) elicited a strong agreement in the area of engagement.

For teams considered to lack a high level of engagement, a couple explanatory factors were commonly noted by coaches:

- Team member are too busy in their jobs to fully participate in project and/or leadership components.
- There is some resistance among members to idea of leadership learning.
- External factors (e.g., summer recess, organizational directives) necessitate delays.

Coach assessment of engagement at mid-point was significantly positively related to their assessment of leadership progress at the end of the program ($p < .05$). Meaning if the teams were perceived as being highly engaged at the mid-point, they were also perceived to have progressed as expected in the area of leadership development. The same level of significance was not detected for project progress, so coaches’ perception of engagement in NLAPH does not appear to be related to project progress.

2. Team Structure & Characteristics

Most of the teams had stable membership throughout the course of NLAPH participation (15/19) and were able to advance their teams’ stage of development and strengthen their team’s functioning.

At baseline, over half of the teams were at the “forming” stage of development, which is the stage in which you establish expectations, build trust, and agree on goals. At the follow-up assessment all but one team were in the “norming” and “performing” stages of development (see **Table 20**). This change was found to be significant at the $p \leq 0.001$ level (mean at baseline 1.95, mean and follow-up 3.42).

Table 20: Team Stage of Development (pre/post)

	PRE (n=20)	POST (n=19)
Forming (1)—establishing expectations, developing trust, agreeing on common goals	55% (11)	--
Storming (2)—identifying power and control issues, gaining skills in communication, reacting to leadership	10% (2)	5% (1)
Norming (3)—members agree about roles and problem solving processes, decisions are made through negotiations and consensus	25% (5)	47% (9)
Performing (4)—achieving effective and satisfying results, collaborative work, members are interdependent and care about each other	10% (2)	47% (9)

Additionally, analyses of the baseline and follow-up survey responses indicate that teams had more self-rated positive characteristics at the end of the program than at the beginning of the program year (see **Table 21**). Team ratings were most improved, to a statistically significant degree, for **achieving an agreed upon decision-making style within the team** (diff: .69, $p \leq 0.001$). Other significant improvements were observed for **team communication system existing that supports accountability** (diff: .40, $p = .011$); **team members comfortable holding each other accountable to decisions and action items** (diff: .33, $p = .010$); and **existing team collaboration sufficient to achieve local project goals** (diff: .43, $p \leq 0.001$).

Though it was not assessed at follow-up, a significant number of respondents answered ‘don’t know’ to the team characteristics in the baseline assessment. Between 21% and 41% of respondents selected “don’t know” for all team characteristics questions at baseline. Particularly high percentages of participants responded ‘don’t know’ were documented for ‘members are comfortable holding each other accountable to decisions and action items’ (41%); ‘an agreed upon decision-making style is in place within our team’ (37%), which were both areas of significant improvement (see **Table 21**).

Table 21: Team Characteristics (pre/post)

Survey item (4=Strongly Agree, 1=Strongly Disagree)	PRE Mean	POST Mean	Mean Difference	Level of significance
Trust exists among members of our project team	3.63	3.73	0.10	P=.200
Team members are open and transparent with their points of view	3.64	3.70	0.06	P=.580
An agreed upon decision-making style is in place within our team	2.72	3.41	0.69	p≤0.001*
Team members are able to openly dialogue about differing points of view in the spirit of finding the best solution(s)	3.62	3.79	0.17	P=.058
Individual members are committed to team decisions, even if they initially disagreed with the direction proposed	3.51	3.59	0.08	P=.540
A team communication system exists that supports accountability	3.09	3.49	0.40	P=.011*
Team members are comfortable holding each other accountable to decisions and action items	3.20	3.53	0.33	P=.010*
The team can be effective in promoting policy and systems change	3.51	3.55	0.04	P=.687
Existing team collaboration is sufficient to achieve local project goals	3.19	3.62	0.43	p≤0.001*

In the participant interviews, about half of the respondents (n=9) indicated that their teams had grown stronger during Academy participation and four said that individual team members had benefitted from team membership. Interview respondents commonly attributed team growth and development to time spent working together, a sense of common purpose, and feeding off of their collective success. Examples from participants include:

- *“As a direct result of the program, our leadership team has been able to strengthen our coalition work as a group.”*
- *“Being together a great deal enabled us to take more risks and put ideas out there in a safe environment.”*

Coaches observed variability in team growth and development, but noted many examples of success. The majority of coaches (n=6) said that interpersonal dynamics were a predictor of team development, and that teams developed more effectively when they learned the languages and cultures of the other sectors.

“Learning about other sectors’ culture and language...and vulnerabilities builds a whole new group of contacts and possible partners.”
- NLAPH Coach

At the end of NLAPH, the majority of teams reported that they will continue to work together on their NLAPH project (16/19) and intend to work together on a different project in the future (12/19). Example comments include:

- *“We progressed, so I think we’ll continue to work together. We understand each other, know our roles, and respect each other.”*
- *“We really have been able to catalyze change in the environment. It has been a good experience and I think we’ll continue to work together.”*

Additionally, about two-thirds of NLAPH teams (68%) were comprised of members from a larger project, consortium or team that was working together. These teams will likely continue to meet after the end of NLAPH. Most of these teams involved in a larger effort reported at least somewhat sharing information learned through NLAPH with the larger team (77% reported that they shared information a great deal or somewhat). This most often included sharing strategic information, such as the “Big Picture” worksheet with partners, but some teams shared information from the retreat and webinars during regularly scheduled meetings, newsletters or email blasts.

3. Intersectoral Collaboration

Teams and individuals regularly reported improved abilities to work across sectors as a result of participating in NLAPH. As was discussed above, 73% of participants had improvements in how they rated their abilities related to the ‘Working Across Sectors’ domain and 95% of individual respondents (n=68) reported that participating in NLAPH had increased their ability to work effectively across sectors. Additionally, 84% of teams (n=19) reported that participation in NLAPH at least somewhat impacted their team’s ability to successfully engage other sectors in their project (with 37% saying it impacted it a “great deal”).

At the mid-term assessment, 15 participants reported successes related to working across sectors. Common themes in these comments included **stronger community and stakeholder engagement, expanded networks, and improved team collaboration.**

In the follow-up assessment, the majority of teams (n=19) reported regularly engaging other sectors and leveraging the individual networks of team members:

- 74% of teams report “regularly” involving sectors other than their own in planning, policy-making and problem solving
- 63% of teams report leveraging the individual networks of team members “a great deal”; with the rest saying that they did “somewhat” (37%)

The increased ability to work across sectors was credited to the ability to bring in key

“Although the members of our NLAPH team had a history of working together... the NLAPH year has been able to bring us together in a more effective way. We have been able to get to know each other both professionally and personally. We are now able to better understand each respective organization, how it functions and how it can be used to the benefit of our project. We were able to utilize the expertise within each of our individual organization.”

- NLAPH Participant

stakeholders and increased collaboration among team members. As was discussed in the ‘Network Development’ section above, in the individual follow-up assessment (n=68), over 80% of respondents indicated that NLAPH contributed to at least moderate growth of the **size** and **strength** of their *local professional network*, which many credited to exposure to their teammates’ existing networks and their project-related outreach to sectors and organizations they had not previously engaged.

“...the program provided an opportunity for our team to forge new ties with key stakeholders by engaging and maintaining better cross-functional collaboration/communication to increase CHI activities.”

- NLAPH Participant

Very few participants described challenges related to intersectoral collaboration. The challenges that were identified included: the difficulty of developing messaging that is effective across sectors (n=2), and the difficulty of engaging new stakeholders within the constraints of a difficult political environment (n=1).

C. Project Progress

In the follow-up individual assessment, the majority of respondents indicated that the NLAPH had contributed to progress on or success in their team’s project at least somewhat, with 59% saying that it contributed “a great deal” (n=68). In the follow-up team assessment, almost 56% of teams (n=11) reported that they made more progress on their project than they expected, with an additional 16% saying they made about as much progress as was expected.

1. *Project progress & milestones*

In interviews at the end of participation, most participants (13/18) said that their project had progressed as a direct result of Academy participation. They mentioned contributing factors, which included: time spent working with their team, improved collaboration in their local environment, and NLAPH training components (retreat, coaching, webinars). Examples of participant comments include:

- *“Our project definitely benefitted from Academy training.”*
- *“I think we did a better job [because of NLAPH participation]. This project had to be done, regardless, but I think the quality is much better because of the Academy. It would have been a more seat-of-the-pants effort without the Academy.”*

Prior to participating in NLAPH, half of the teams who needed to conduct a needs assessment had already done so and about a quarter of the teams came into NLAPH with consensus on their community health improvement project and goals. The

specific project areas where the most teams made either a great deal of progress or were able to complete during NLAPH included:

- Identifying key stakeholders necessary for project success (80%)
- Developing a project action plan or workplan (74%)
- Achieving team consensus on community health improvement project and goals (69%)

Just over half of the teams indicated that they made substantial progress on implementing their project activities and had determined next steps for the project team when NLAPH ended (see **Table 22**).

Table 22: Key Project Milestones

	Completed prior to NLAPH	Completed during NLAPH	A great deal of progress	Moderate progress	Limited progress	No progress	N
Achieve team consensus on community health improvement project and goals	26%	37%	32%	--	5%	--	19
Conduct a needs assessment (formal or informal)	50%	13%	31%	--	6%	--	16
Develop a project action plan or workplan	--	58%	16%	16%	11%	--	19
Identify key stakeholders necessary for project success	5%	48%	32%	16%	--	--	19
Engage community and/or key stakeholders	--	26%	37%	21%	16%	--	19
Implement activities in accordance with project plan and timeline	6%	19%	38%	25%	13%	--	16
Determine next steps for team and project after Academy year ends	6%	22%	33%	33%	--	6%	18

The majority of teams (84%, 16/19), when asked explicitly in the follow-up survey, indicated that their team will continue to work on project after NLAPH. Plans to continue working together included: (1) fulfilling goals of the project by proceeding with project implementation (n=12); (2) continue to meet with partners/coalition (n=6); and (3) work to bring in more assistance and engage more partners (n=4). Those who indicated that they would not continue to work on the project indicated that either the project would be completed by another organization or that, individually, they would continue working on the project, but not as a team.

As was mentioned earlier, about two-thirds of NLAPH teams (68%) were comprised of members from a larger project, consortium or team that was working on a larger project. The project fit into these larger efforts in different ways. Most commonly, the project was part of a larger initiative that was being directed by a state or local coalition or agency, such as the public health department. A few teams mentioned that NLAPH participation prompted members to become part of an already existing coalition that was focused on the same priorities.

Teams were asked to report on **project progress** as part of their Culminating Reports, presented and submitted in January-February 2013. A summary of the Culminating Reports can be found in **Appendix J**.

2. Coach Assessment of Project Progress

Coaches were asked to rate their teams’ progress on their project (as well as leadership learning (**Table 18** above)) as part of the mid-term and follow-up assessment. At mid-term, 60% of the teams were seen to be making expected levels of progress on their projects and 40% were not. At the end of the program, coaches indicated that 14/16 (88%) teams made expected levels of progress on their project (see **Table 23**). As mentioned earlier, only 72% of teams felt they made as much progress as expected on their project, which may suggest that teams had higher expectations than coaches about what was realistic to accomplish as part of NLAPH.

Table 23: Coach Assessment of Project Progress

Teams are making expected levels of progress in their projects	#/% of teams	
	Mid-term (n=20)	Follow-up (n=16)
Strongly Agree	3 (15%)	8 (50%)
Somewhat Agree	9 (45%)	6 (38%)
Somewhat Disagree	3 (15%)	2 (14%)
Strongly Disagree	4 (20%)	--
Don't know	1 (5%)	--

Most coaches (n=7), in interviews at the end of the program, noted variability in the progress of projects and cautioned that it is difficult to measure progress on intersectoral projects over such a short time period. Initially, coaches talked frequently about the unrealistic scope and scale of many projects and that teams struggled to articulate what needed to be accomplished and how they would move the project forward. For example, in the coaches' mid-term assessment several project related challenges were noted:

- *“Initially, they were much too ambitious in how they scoped the potential for their project’s collective impact. They perhaps lost time learning that they needed to scope down to a more “winnable” battle.*
- *“Addressing social determinants of health in schools is important work, but the team may not have the spheres of influence they need to accomplish this work.”*
- *“Addressing public health issues through policy change is a challenging prospect in a politically charged environment, which is further exacerbated by the approval and upholding of the Affordable Care Act and as the November elections approach. (This) is typically considered a conservative state, and government intervention is often viewed as an affront to individual liberties.”*

Projects were also subject to external forces, particularly if occurring as part of a larger effort. One coach provided this example: *“We were notified in July by the team leader that the community project has been put on hold by the community health coalition that created the environment for the project...As of early September, we have not been given indication that they are in a position to resume.”*

Coaches indicated that teams that made progress on their projects had strategically mapped out what needed to be done and had identified/taken concrete action steps. Examples of coach comments about project progress included:

- *“From a project point of view, there was pretty much consensus early on that most of these people were not going to achieve their goals in this period of time. The project was a mechanism to be used for learning about leadership.”*
- *“They have made decent progress and have mapped out the strategy to further develop the project and identify additional resources and activities.”*
- *“They were able to engage a critical partner. They recognized the need to involve the State Office of Primary Care. They successfully brought them on and it really helped the project progress.”*
- *“They really moved the project forward. They developed and approved a protocol for hospitals to (implement project goals). They were successful in facilitating development of a data system to get reports from hospitals on*

[project goals]. There were very accomplished at putting together team training webinars, written materials, and web-based materials for those involved in [project goals].

3. Project Change & NLAPH Contribution

In the follow-up team assessment (n=19), nearly half (9) of the teams reported that their project had changed significantly in scope or scale during the course of participation in the Academy. Six of the teams indicated that their coaches played an important role in changing the scope or scale of the project in order to make it more viable and effective. Five teams cited things they learned at the NLAPH kickoff and in webinars as important factors in their decisions to change their projects' scope or scale. Common issues that required project change were identified in participant interviews. They included "projects had to adjust to reality," changed funding environments, changed political environments, and teams discovering that they needed to act as part of a larger existing coalition working on similar issues.

Representative quotes from interviews:

- *"We had a grander idea. We were hoping to do (the intervention) in the community and through school-based delivery as well. But now we're doing it in an almost modular approach. We'll operationalize the childhood [intervention] first, then repeat with other efforts."*
- *"When we first started, we had an intention of completing the project and being the ones to lead it. Then we learned that we needed to...build relationships in the community with other people who were already working on the same issues. By the end, we had taken more of a support role for other organizations in the community."*
- *"[Our coach] said to stop looking at the larger population and start looking at the 50-100 people that are actually driving 80% of the cost in your county."*
- *"I think [our coach] really helped us realize we needed to be out there talking to the community. We had top-down thinking, but we realized that isn't the best way to go about it and reached out to those groups already working on it."*
- *"After the retreat, we saw that we really needed to narrow our focus if we wanted to get this done."*

IV. Recommendations

CCHE offers the following recommendations for consideration based on the data collected during the NLAPH pilot year. Some of these recommendations may have already been addressed during the planning for Cohort 2, but are offered here to highlight areas for improvement based on the data collected about and from Cohort 1 teams.

- **Increase opportunities for networking across teams.** One of the most common requests from participants was to have more time to network and learn from the other NLAPH teams. Several ideas were proposed as to how to increase networking opportunities:
 - Allow more time at the national retreat for networking
 - Engage teams in sharing their expertise/experience in webinars
 - Match teams with other implementing similar projects (e.g., form “affinity groups”) to encourage more sharing across projects
 - Add additional in-person convenings—either nationally or regionally
- **Increase the time available for coaches to spend with teams.** Both coaches and participants indicated that there was insufficient time for the coaches to interact with the teams. While the cost may prohibit increasing the time allocated for each team, almost all teams indicated that it would have been valuable to have had more time with their coaches. Many teams also expressed an interest in the coach following up with them after their participation in the NLAPH ends to assist with any challenges that may arise.
- **Define the key readiness characteristics of NLAPH teams and utilize these qualities in the recruitment process of future cohorts.** Team “readiness” seemed to have been an important factor in determining whether a team was engaged in the Academy and made progress in leadership and/or their community health improvement project. Based on feedback from the mid-term report, lessons learned about readiness factors were incorporated into recruitment efforts for Cohort 2.
- **Formalize the curriculum and coaching model.** During the pilot year, the curriculum was evolving as the program was being implemented. This caused some uncertainty among coaches about how to best reinforce the curriculum during their coaching sessions. Additionally, there was not a clear coaching model used across coaches with Cohort 1 teams. Coaches adjusted their approach to the needs of the teams and their own strengths, which resulted in significant variation between coaches. Going forward, it would be helpful to more clearly articulate the curriculum and coaching model so that it can be implemented consistently and so that fidelity to the model can be assessed.

While there is value in formalizing the model, participants and coaches also appreciated that there was flexibility to meet individual needs. In defining the “model” (particularly for coaching), it should be noted which are the critical components and where adjustments can be made to meet individual team needs.

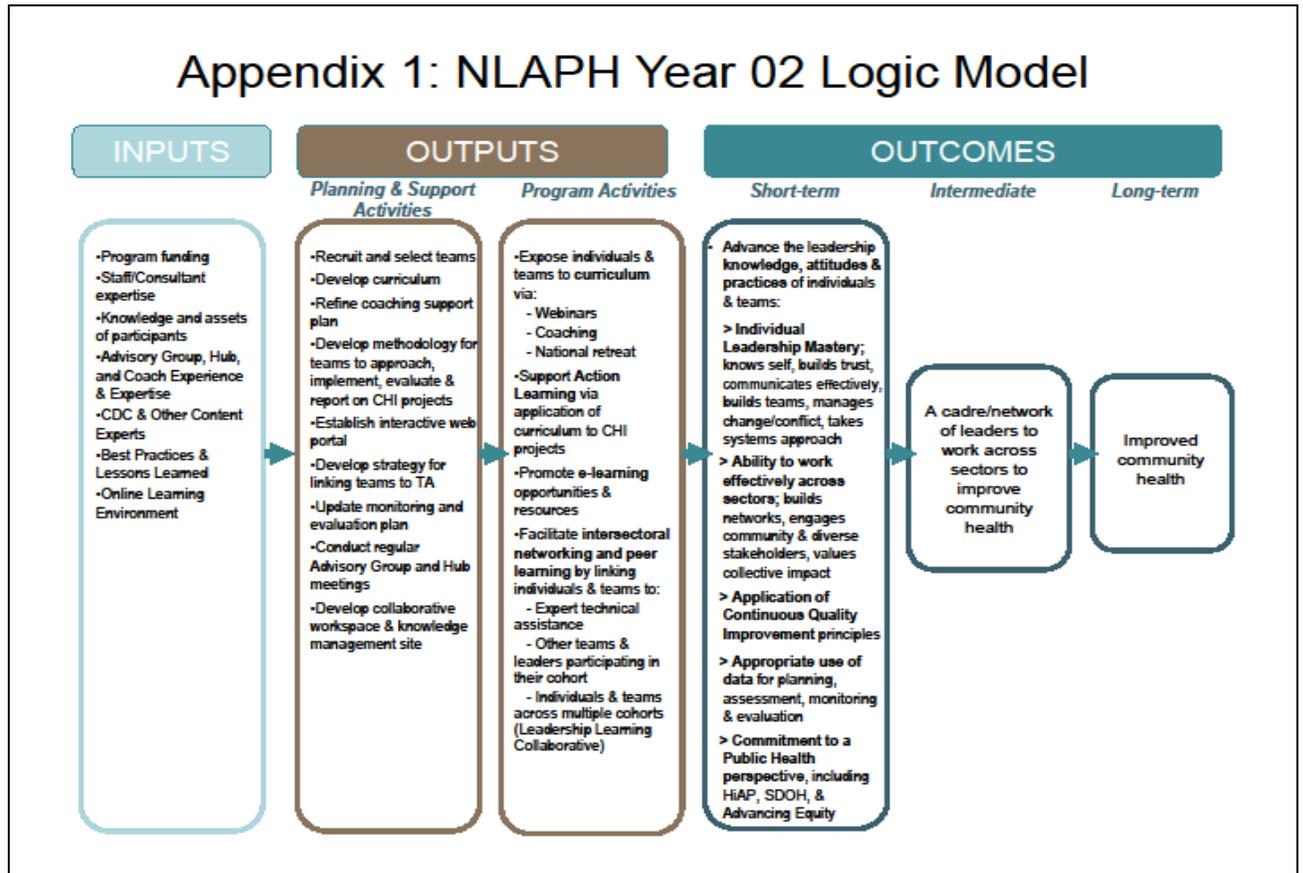
- **Continue the key program delivery components.** The evaluation of the pilot year suggests that the key program delivery components—national retreat, webinars, coaching, and network development—are all contributing to the desired outcomes, and should be continued.
- **Ensure that the core curriculum meets the needs of various levels of leaders.** Participants in Cohort 1 came into the program with varying backgrounds in terms of experience in their sector, level of leadership, and experience and expertise in public health topics. In the post-retreat and webinar surveys, some participants indicated that certain webinar and retreat sessions were too elementary for them. Ideally, the core curriculum would be designed to meet the needs of all levels of participants. Core webinars are probably best targeted to the middle, but it may be possible to cover more basic and more advanced issues via the elective webinar offerings.
- **Increase promotion of phConnect to increase networking/peer learning.** Utilization of phConnect was low throughout the pilot year. Participants reported that phConnect was not user friendly and so they didn’t access it frequently. If this will continue to be the online platform for networking/peer learning, look for more opportunities to drive people to the site (e.g., post questions to follow up to each webinar to encourage continued discussion, encourage coaches use it for interaction with teams, etc.)
- **Continue to engage and support alumni.** In the follow up assessment, participants indicated in an interest in continuing to be engaged in the NLAPH. Many participants requested continued access to the achieved materials as well as the live webinars and any additional materials being offered to subsequent cohorts. Participants also suggested that it may be valuable to engage the alumni in the retreat and webinars as either peer mentors or presenters to share their experience and learnings with the new cohort.
- **Package curriculum material at the end of NLAPH for alumni to easily access materials.** Related to supporting alumni, several participants expressed a desire for the curriculum to be “packaged” at the end for them to more easily access and reference materials. Suggestions for how to package the material included binders of materials, CDs, and zip files so all of the materials could be downloaded as a batch (rather than individually). Packaging the materials would also help to clarify what the core curriculum entailed.

- **Strengthen webinars by incorporating the “most valuable components” identified by participants.** Cohort 1 participants identified several things that made the webinars more valuable, including: interactivity, practical examples, diverse speakers, and involvement of NLAPH teams. These components should be prioritized when planning future webinars. Many participants also spoke of some technical difficulties with the webinars, and emphasized that both presenters and participants should be oriented to the system to ensure that the webinars can be implemented smoothly.
- **Continue to emphasize evaluation and look for opportunities to improve existing evaluation efforts.** The evaluation results from Cohort 1 can be used to facilitate a discussion with key stakeholders about whether the evaluation, as currently designed, is able to answer the questions they have about the program. These discussions can help to inform adjustments to the evaluation of subsequent cohorts. Reflecting on the evaluation for Cohort 1, CCHE believes the evaluation could be strengthened by:
 - Clarifying leadership learning goals and linking the “big picture” to team outcomes at the program’s outset.
 - Determining a way to assess “intensity of participation” for individual participants.
 - More consistent data on the extent and focus of coaching services delivered to individual teams.
 - Ability to follow-up with teams six months to one year after participation ends to be able to assess longer-term outcomes related to leadership development and progress on the applied health learning project.

Appendix A: Timeline of Program Components

NLAPH Year 1 Program Delivery Timeline to date	
February 24, 2012	Webinar 1: NLAPH Program Launch
February 27 – March 9	Participant registration for phConnect
February 28 - March 21	Individual Baseline Assessments
February 28 - March 21	Team Activity 1: Team Self-Assessments (baseline)
March 13 & 15	Webinar 2: Leadership Models We Can Learn From
April 12 - April 27	Myers-Briggs Type Indicator Assessments
April 3 & 9	Webinar 3: Collective Leadership
April 16 - May 4	Team Activity 2: The Big Picture
Late April	Team Coach Assignments Announced
May 6 - 9	Annual Conference—Atlanta, GA
July-September	Coach Site Visits to Teams
July 31	Webinar 4: Improving Community Health—Getting the Work Done
August 2 & 23	Webinar 5: Framing the Message
September 19 & October 12	Webinar 6: Tension of Turf – Tools for Intersectoral Leadership
November 1 & 6	Webinar 7: Why Policy Matters
December 14	Webinar 8: Got Data – Leading with a CQI Mindset
January 8 & 10, 2013	Webinar 9: Sustainability Planning
January 30	Webinar 10: Final Program Webinar
February	Culminating Reports
February	Individual & Team Follow-up Assessments

Appendix B: NLAPH Logic Model



Appendix C: NLAPH Cohort 1 Teams

Team Location	Scope	Member Affiliations
California	Statewide	<ul style="list-style-type: none"> California Department of Public Health (4)
Louisiana	Statewide	<ul style="list-style-type: none"> Louisiana Public Health Institute Louisiana Hospital Association Louisiana Dept of Health and Hospitals, Office of Public Health Louisiana Rural Health Association
Maryland	Statewide	<ul style="list-style-type: none"> Maryland Dept of Health and Mental Hygiene University of Maryland School of Medicine Cambridge Pediatrics, LLC Anne Arundel Medical Center
Ada, Boise, Elmore & Valley Counties, Idaho	Multi-county	<ul style="list-style-type: none"> Central District Health Department Treasure Valley Family YMCA Boise State University Idaho Dept of Health and Welfare
Gila, Maricopa & Pinal Counties, Arizona	Multi-county	<ul style="list-style-type: none"> Arizona Chapter of the American Academy of Pediatrics Arizona Partnership for Immunizations Maricopa County Public Health Madison School District
Panhandle, Nebraska	Multi-county	<ul style="list-style-type: none"> Nebraska Healthcare Network Panhandle Public Health District Chadron Community Hospital and Health Resources Community Action Partnership of Western Nebraska
Burlington County, New Jersey	County	<ul style="list-style-type: none"> Burlington County Health Department (2) TCNJ Virtual Health Promotion Services
Frederick County, Maryland	County	<ul style="list-style-type: none"> Frederick County Health Department Frederick Regional Health System United Way of Frederick County Maryland Dept of Health and Mental Hygiene
Fulton County, Georgia	County	<ul style="list-style-type: none"> Fulton County Dept of Health and Wellness Georgia State University Grady Health System Children's Health Center at Emory
Los Angeles County, California	County	<ul style="list-style-type: none"> County of Los Angeles Dept of Public Health (2) Community Clinic Association of LA County Emergency Network of Los Angeles
Maricopa County, Arizona	County	<ul style="list-style-type: none"> Maricopa County Dept of Emergency Management Maricopa Integrated Health System Maricopa County Dept of Public Health Homeland Defense Bureau

Team Location	Scope	Member Affiliations
Martinsville & Henry County, Virginia	County	<ul style="list-style-type: none"> • Piedmont Community Services • Virginia Dept of Health, Henry-Martinsville Health Dept • Martinsville YMCA • West Piedmont Health District
Nassau County, New York (Preparedness)	County	<ul style="list-style-type: none"> • Nassau Center for Health Initiatives • New York Institute of Technology • Applied Science Foundation for Homeland Security • Nassau County Department of Health
Nassau County, New York (SIDS)	County	<ul style="list-style-type: none"> • Sudden Infant and Child Death Resource Center • Nassau County Department of Social Services • Nassau County Department of Health • Safe Kids
New London County, Connecticut	County	<ul style="list-style-type: none"> • Community Health Services, Inc • Connecticut Department of Public Health • Connecticut Hospital Association • Ledge Light Health District
Osceola County, Florida	County	<ul style="list-style-type: none"> • Osceola County Health Department • Florida Hospital • Health Council of East Central Florida, Inc. • Community Vision
Stark County, Ohio	County	<ul style="list-style-type: none"> • Mental Health and Recovery Services Board of Stark County • Manager of Prevention, OCPS I • The Employment Source • University of Mount Union
Blue Island, Illinois	City/tribal	<ul style="list-style-type: none"> • City of Blue Island (2) • MetroSouth Medical Center • Salvation Army
East Orange, New Jersey	City/tribal	<ul style="list-style-type: none"> • Newark Community Health Centers, Inc • Gateway Northwest Maternal and Child Health Network • East Orange Health Department • University of Medicine and Dentistry of NJ - NJ Medical School
Hannahville Indian Community, Michigan	City/tribal	<ul style="list-style-type: none"> • Childcare Director • Hannahville Indian Community Health Center (2) • Hannahville Indian School

Appendix D: Delivery of Intended Program Elements

Key component	Delivery notes
Applied, team-based collaborative leadership training model, emphasizing multi-sectoral teams and community health improvement projects	<ul style="list-style-type: none"> ✓ Applied: teams worked on their identified community health projects throughout the program. These projects served as a “testing ground” to provide the teams with opportunities to put new public health leadership knowledge into practice. ✓ Team-based: teams of four participated, and coaching was generally provided to the team rather than individual level. ✓ Multi-sectoral teams: As noted in the background section, nearly all teams were composed of individuals from across difference sectors. ✓ Community health improvement projects: each team identified its community health improvement project at the time of application. Coaches worked with teams to integrated leadership learning into these projects.
Flexible program design: including core and elective curriculum elements, guided by baseline needs assessment	<ul style="list-style-type: none"> ✓ Core and elective curriculum elements: The core curriculum to date includes ten webinars, as well as the group presentations, activities and exercises provided at the retreat. A list of elective webinars and links was provided to participants. ✓ Responsive to baseline needs assessment: The individual and team baseline assessments identified five domains in which participants would benefit from knowledge and skill building. Although these were not all specified in the original model, these were incorporated into the new competency sets.
On-site and distance learning modalities: web-based trainings; in-person national retreat; and coaching support to teams; with use of didactic sessions, case examples, exercises/activities, and feedback/support.	<ul style="list-style-type: none"> ✓ On-site: These components included the onsite retreat in Atlanta, as well as site visits by coaches. ✓ Distance: Webinars were conducted remotely, as are coaching calls. ✓ Didactic sessions: Webinars and retreat ✓ Case examples: Webinars and retreat ✓ Exercises/activities: Retreat ✓ Feedback/support: Retreat and coaching
Promotion of networking opportunities for participants	<ul style="list-style-type: none"> ○ phConnect: All participants were members of the NLAPH phConnect site, which allowed team members to easily post messages on other teams’ pages. Use of phConnect throughout the program year was limited. ✓ Strategic linkages: Coaches reported linking teams that are working on similar issues for increased peer collaboration and support.
Use of experts and partners from around country to inform programming and facilitate webinars.	<ul style="list-style-type: none"> ✓ Advisors: Experts and partners engaged in program planning, curriculum design, etc. ✓ Coaches: Well-established leaders from around country. ✓ Speakers: Nationally known experts and partners as speakers in retreat and webinars.

Appendix E: Webinar Descriptions

Webinar #	Title	Speaker(s)/Topic(s)	Objectives	Date(s)
Webinar 1	NLAPH Program Launch	<p>Program Overview: Carmen Nevarez</p> <p>Curriculum Hub: Deborah Meehan, Leadership Learning Community</p> <p>Coaching and Technical Assistance: Arthur Chen, MD, Asian Health Services</p> <p>E-Learning and Technology: Milano Harden, The Genius Group, Inc.</p> <p>Evaluation: Bill Beery, Center for Community Health and Evaluation</p>	<ul style="list-style-type: none"> • Participants will have a shared understanding of the Academy’s purpose, goals and staff team • Participants will have a shared understanding of an overview of the program structure and elements. 	February 24
Webinar 2	Leadership Models We Can Learn From	<p>Meta Leadership Model: Curtis Weaver, CDC</p> <p>Leadership from a Tribal Perspective – Cherokee Nation Leadership Model: Chief Chad Smith</p>	<ul style="list-style-type: none"> • Exposure to two models of leadership • Stimulate thinking about what it means to lead in different contexts • Stimulate thinking about what it means to bring self into how you are leading 	March 13 & 15
Webinar 3	Collective Leadership	Kelly Hannum, Center for Creative Leadership	<ul style="list-style-type: none"> • Shared understanding of how Collective Leadership is defined • Exposure to current research and new understanding of how leaders create direction, alignment and commitment 	April 3 & 9
Webinar 4	Improving Community Health—Getting the Work Done	<p>Moving the Work in Conservative Communities: Dr. Edward Moreno, County of Fresno (CA), Department of Public Health</p> <p>Obesity Prevention and the Built Environment: Mary Balluff, Community Health and Nutrition Services at Douglas County (NE) Department of Health</p> <p>Leadership Lessons from Community Health Improvement Work: Dr. Eric Baumgartner, Louisiana Public Health Institute</p>	<ul style="list-style-type: none"> • Understand what it means to be a community health improvement leader • Understand what it means to have the ‘right’ stakeholders at the table • Understand how to ‘move’ work forward in a variety of contexts and related to any community health improvement topic 	July 31

NLAPH Cohort 1 Follow-up Report – May 2013

Webinar #	Title	Speaker(s)/Topic(s)	Objectives	Date(s)
Webinar 5	Framing the Message	Sana Chehimi, Prevention Institute Ingrid Daffner Krasnow, Berkeley Media Studies Group	<ul style="list-style-type: none"> • Learn what framing is, and how it works in our heads and in the news media. • Understand the importance of the “environmental” frame to promote policy change • Learn to use messages that state your values & put the solution first. • Share lessons from the field. 	August 2 & 23
Webinar 6	Tension of Turf – Tools for Intersectoral Leadership	Sana Chehimi, Prevention Institute Mark Horton, Former California State Health Officer	<ul style="list-style-type: none"> • Understand intersectoral work • Understand turf struggles • Understand the causes of turf struggles • Learn techniques to address turf struggles 	September 19 & October 12
Webinar 7	Why Policy Matters	Robert S. Ogilvie, ChangeLab Solutions	<ul style="list-style-type: none"> • Understand how to create a policy • Understand how to engage the community in policy work • Understand how to engage politicians and other stakeholders in policy work • Understand what policy angle to take with work • Understand how policies can move my team’s work forward 	November 1 & 6
Webinar 8	Got Data – Leading with a CQI Mindset	Carmen Nevarez Art Chen	<ul style="list-style-type: none"> • Understand how to lead with a quality improvement mindset • Understand how to use data for planning, decision making and influencing others • Understand the importance of working with community to gain their perspective as the data is analyzed 	December 14, 2012
Webinar 9	Sustainability Planning	Tanya Kleinman, Center for Civic Partnerships	<ul style="list-style-type: none"> • Learn a 10-step process and tools for sustainability planning • Discuss strategies and potential next steps for sustaining programs and efforts 	January 8 & 10, 2013
Webinar 10	Final Program Webinar	Team presentations	<ul style="list-style-type: none"> • Promote cross team sharing and learning from the NLAPH experience • Promote network building within the NLAPH community • Provide closure to the NLAPH program 	January 30, 2013

Appendix F: Elective Webinars by Topic

(as listed on NLAPH page on phConnect)

Policy/ Government Engagement

1. Health in All Policies: http://dialogue4health.org/webforums/9_6_12.html
2. Educating Elected Officials: Effective Strategies for Prevention and Public Health: http://dialogue4health.org/hcr/10_13_11.html
3. Engaging Your Elected Officials in the Fair Health Movement: http://dialogue4health.org/php/jointcenter/placematters/4_15_09.html
4. Health Impact Assessments: How Communities and Government can Work Together to Improve Community Design: http://dialogue4health.org/webforums/8_5_09.html
5. Systems Thinking and Racial Justice: <http://leadershiplearning.org/blog/bcelnik/2011-05-18/slides-professor-john-powells-webinar-systems-thinking-and-racial-justice>

Community Engagement

6. Using Social Media to Promote the Fair Health Movement: http://dialogue4health.org/php/jointcenter/placematters/9_1_10.html
7. Leadership + Partnership + Implementation = Community Engagement: http://dialogue4health.org/php/jointcenter/placematters/10_28_09.html
8. Communicating About Place Matters (Part 1): Developing your message: http://dialogue4health.org/php/jointcenter/placematters/9_9_09.html
9. The Community Learning Exchange Story: Connecting the Wisdom and Leadership of Place: <http://leadershiplearning.org/blog/admin/2012-07-26/2012-webinar-community-learning-exchange-story-connecting-wisdom-and-leadershi>

Tools

10. Community Commons: Using the Platform and Tools to Inform and Advance Prevention, Wellness and Public Health Related Efforts: http://dialogue4health.org/hcr/6_7_12.html
11. Harnessing Maps and Mapping Tools to Advance Health Equity: http://dialogue4health.org/php/jointcenter/11_07_08.html
12. Internet Strategies Map4Change Demo: http://dialogue4health.org/php/jointcenter/placematters/2_15_11.html
13. Harnessing Maps and Mapping Tools to Advance Health Equity: http://dialogue4health.org/php/jointcenter/11_07_08.html

Data

14. Got Data? California Counties Take Action with the County Health Rankings & Roadmaps Program: http://dialogue4health.org/webforums/5_18_12.html
15. Benchmarking 101: Measuring Your Progress: http://dialogue4health.org/php/jointcenter/placematters/7_22_09.html

Built Environment

16. Healthy Homes: You Are Where You Live:

http://dialogue4health.org/webforums/1_19_12.html

17. The Built Environment: Health Policy in Concrete:

http://dialogue4health.org/webforums/11_29_11.html

18. Designing Healthy Communities: Uniting the Missions and Perspectives of Public Health and Urban Planning: http://dialogue4health.org/webforums/10_12_11.html

19. Place Matters 2012 Program Plans:

http://dialogue4health.org/php/jointcenter/placematters/11_7_11.html

Transportation

20. Where the Rubber Meets the Road: Promoting Active Transportation in Rural Areas -

http://dialogue4health.org/webforums/4_24_12.html

Physical Activity

21. Programs and Policies to Get Kids Active Outside of School Time:

http://dialogue4health.org/webforums/8_8_12.html

22. Improving School Policies and Settings to Increase Physical Activity:

http://dialogue4health.org/webforums/3_28_12.html

23. Green Places, Play Spaces, Income, and Race: How Parks and Recreation Can Support Physical Activity among Diverse and Underserved Populations :

http://dialogue4health.org/webforums/1_18_12.html

24. Getting Physical: The Public Health Approach to Active Living:

http://dialogue4health.org/webforums/12_7_11.html

Multi-Sector Collaboration

25. Crossing Sectors and Leading Change: Environmental Interventions Targeting: Obesity

http://dialogue4health.org/webforums/9_12_11.html

26. Healthy People 2020: A New Blueprint for Preventative Health:

http://dialogue4health.org/webforums/10_2_09.html

General Leadership

27. Are you a network weaver? <http://leadershiplearning.org/blog/natalia-castaneda/2011-06-07/upcoming-webinar-are-you-network-weaver>

Appendix G: Responses to Individual Webinar Objectives (sample)

Webinar # and title	Key objective	A lot	Somewhat	A little or not at all
1: Program Launch	Enhanced understanding of the NLAPH program components (n=66) ⁵	73%	24%	<1%
2: Leadership Models We Can Learn From	Enhanced your understanding of leadership models (n=54) ⁶	78%	19%	3%
3: Collective Leadership	Enhanced your understanding of collective leadership (n=57)	70%	26%	4%
4: Improving Community Health – Getting the Work Done	Taught you how to ‘move’ work forward in a variety of contexts and related to any community health improvement topic (n=22)	50%	45%	5%
5: Framing the Message	Presented you with the tools to “frame the message” of your community health improvement work (n=19)	89%	11%	--
Webinar # and title	Key objective	Agree strongly	Agree somewhat	Disagree
6: Tension of Turf – Tools for Intersectoral Leadership	Provided me with techniques to address turf struggles (n=25)	48%	44%	8%
7: Why Policy Matters	Increased my understanding of how policies can move my team’s work forward (n=32)	34%	50%	16%
8: Got Data – Leading with a CQI Mindset	Helped me understand how to use data for planning, decision making and influencing others (n=20)	40%	50%	10%
9: Sustainability Planning	Helped me understand the next steps for my team in regards to sustainability planning (n=39)	56%	41%	3%
10: Final Program Webinar	Promoted cross team sharing and learning from the NLAPH experience (n=32)	67%	31%	3%

⁵ These are average ratings, the survey asked about 7 components covered in the webinar: NLAPH’s goals and objectives, NLAPH’s curriculum, NLAPH’s timeline, role of coaching and technical assistance, role of phConnect and eLearning, role of evaluation, responsibilities during the program year. Responses were fairly consistent across areas. The highest rated items were understanding of the goals and objectives and the timeline and the lowest rated were understanding of their responsibilities and the NLAPH curriculum

⁶ Average ratings for the two leadership models presented.

Appendix H: Team Progress on Leadership Learning Goals

Thirteen NLAPH teams articulated goals and rated progress on their goals. Teams articulated between 1-4 goals for their team, about 2/3 of the articulated goals were primarily regarding leadership learning, while the other 1/3 were primarily about reaching project goals (see table below).

	Type of Goal	# of Goals	Total # of goals	Average rating (1-5)*
Team 1	Leadership Learning	2	2	3.50
	Project	0		
Team 2	Not articulated	N/A	N/A	N/A
Team 3	Leadership Learning	2	2	N/R
	Project	0		
Team 4	Not articulated	N/A	N/A	N/A
Team 5	Not articulated	N/A	N/A	N/A
Team 6	Leadership Learning	4	4	4.00
	Project	0		
Team 7	Leadership Learning	1	2	2.50
	Project	1		
Team 8	Leadership Learning	3	3	4.67
	Project	0		
Team 9	Leadership Learning	3	3	2.67
	Project	0		
Team 10	Not articulated	N/A	N/A	N/A
Team 11	Not articulated	N/A	N/A	N/A
Team 12	Leadership Learning	1	2	2.00
	Project	1		
Team 13	Leadership Learning	1	3	3.33
	Project	2		
Team 14	Leadership Learning	3	4	3.50
	Project	1		
Team 15	Leadership Learning	3	4	5.00
	Project	1		
Team 16	Leadership Learning	0	4	4.75
	Project	4		
Team 17	Leadership Learning	0	2	4.00
	Project	2		
Team 18	Leadership Learning	3	4	4.50
	Project	1		
Team 19	Leadership Learning	1	1	4.00
	Project	0		
Team 20	Not articulated	N/A	N/A	N/A

*1=no progress, 2=minimal progress, 3=fair progress, 4=good progress, 5=excellent progress

The average rating for all goals was 3.87, which means that teams felt they had made fair to good levels of progress across their goals. All stated that they had made at least minimal progress on all goals. Teams reported good or excellent progress on almost 70% of their goals. The ratings did not differ significantly between leadership learning and project goals (see table below). Over half of the teams (7/13) reported making good to excellent progress on all of their goal).

	1- No progress	2- Minimal progress	3- Fair progress	4- Good progress	5- Excellent progress	TOTAL # of goals	Mean
# of goals (overall)	--	4	8	15	11	38	3.87
# of LL goals	--	2	5	12	6	25	3.88
# of project goals	--	2	3	3	5	13	3.85

Appendix I: Increases in Leadership Competencies by Team

Team	Average # of competencies increased	Range of increased competencies among team members	# of team members who increased in fewer than 5 competencies
Team 1	18.75	17-20	0
Team 2	16.00	11-22	0
Team 3	15.75	13-19	0
Team 4	15.25	1-21	1
Team 5	13.00	7-18	0
Team 6	12.50	9-19	0
Team 7	12.50	2-20	1
Team 8	12.50	5-23	0
Team 9	12.25	5-18	0
Team 10	11.00	6-20	0
Team 11	11.00	1-16	1
Team 12	8.50	5-12	0
Team 13	8.50	1-13	1
Team 14	8.25	1-12	1
Team 15	6.75	0-13	0
Team 16	5.50	0-13	2
Team 17	4.25	0-7	2
Team 18	3.50	3-4	2
Team 19	No data		
Team 20	No data		

Appendix J: Summary of Team Culminating Reports

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
Frederick County, MD	Frederick Regional Health Care System; state health department; local health department; United Way	Oral disease among low-income and uninsured	Facilitate community partnership development and collaboration for oral health; development of a community supported and community sustained dental clinic through establishing new cross sector partnerships	Sectors without experience working with one another and some without dental service backgrounds were brought together; this leadership team was able to focus on highlighting critical success elements	Gained approval by dental school to open satellite student dental clinic in Frederick County; local dentists have volunteered to help in teaching at clinic	Creation of a dental system navigator position; continue oral literacy campaign; budget planning and fundraising with dental school; increase community dentists engagement; form advisory board; draft operational plan; develop dental and support positions
Nassau County - Preparedness	National Center for Health Initiatives; Hofstra School of Medicine; County Health Department; Department of Nursing New York Institute of Technology; Morrelly Center for Applied Science for Homeland Security	Emergency preparedness and response to disease burden within minority, poor, and elderly populations	Development of a capacity building plan to address health disparities and emergency preparedness in communities with priority health needs and willingness and/or ability to participate in an organized effort to promote health and safety.	Development of a cohesive and focused team; interprofessional bond development between members; collaboration with representatives from multiple regions; awareness of synergy building; shared decision-making and commitment to the project	Project clarified; grant application submitted; developed concept paper and stakeholder list initiated; abstract submitted	Submit additional grant and philanthropic support requests; develop academic contributions; enhance community partnerships with key groups; disseminate 'The Big Picture' process template

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
Maricopa County	Maricopa County Public Health; AZ Partnership for Immunizations; Madison School District; AZ Chapter of Academy of Pediatrics	Collaboration and financing for vaccination coverage	Financing of community vaccinations	Strengthened relationships between members improved leadership capabilities as individuals; gained skills related to goal-setting and meeting facilitation, advocacy, and communication; with these skills, this team was able to win over a tough crowd who did not agree on subject but agreed to work with the group	Developed key messaging and legislative recommendations for reimbursing private providers for vaccinations; performed background research to frame the problem	Continue working on re-vamping vaccination finance system; continue regular meetings with team members; put data and messaging together for legislative sessions 2013; encourage public and private provider communities to engage
Idaho	Central District Health Department; Boise State University; YMCA	Childhood obesity prevention in early care settings	Improve nutrition, increase physical activity and limit screen time for children in child care centers. Provide training and technical assistance to targeted licensed child care providers to prepare them to adopt new policies and practices.	Development and practice of meta-leadership skills; understanding of the importance of leading through influence versus authority; succeeded in developing relationships with a diverse group of community partners engaged in the work in child care	Seeking funding opportunities to conduct an assessment of current nutrition and physical activity policies and practices in CDHD’s early child care settings; involved with the Let’s Move Boise Pillar 1 subcommittee; working with the Idaho Association for the Education of Young Children (IAEYC) and BlueCross of Idaho’s Foundation for Health to support an early child care assessment	Plan to support the existing efforts taking place in the community for the reduction of obesity in childcare settings

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
East Orange, NJ	East Orange FQHC; East Orange Health Department; New Jersey Immunization Registry; University of Medicine and Dentistry of New Jersey	Use of technology and outreach workers for the improvement of immunization rates	Use of GIS technology to map NJ Immunization Registry data for two immunization providers. Use of data by outreach workers to follow-up with patients aged 7-months to 2-years who are not up-to-date with their vaccinations.	Development of collective leadership resulting in commitment from stakeholders to develop and implement ideas; the team's self and group awareness, coupled with improved communication and collaboration skills facilitated mapping out the steps that would put our plans into action	Received signed MOA from participating immunization sites; gained buy-in from 4 partner agencies; worked with GIS mappers to develop mapping program, and secured the use of NJ Immunization Registry data from project partners; establishment of a framework for collaborative immunization follow-up for replication in similar projects, and received approval for a second project to improve human papilloma virus (HPV) immunization rates in adolescents	Anticipate using framework for other public health problems; building on the personal contacts and leadership skills gleaned through NLAPH experience; implement project; continue inter-sectoral public health collaboration and interventions; realize full potential of immunization delivery in NJ; establish NJ Public Health Prevention Institute
Maryland (statewide)	The team formed from the Newborn Screening for Critical Congenital Heart Disease work group	Newborn screening for Critical Congenital Heart Disease (CCHD)	Convene representatives from critical partners in order to carry out the task of implementing CCHD screenings	Individual and team growth in the areas of leadership and building partnerships to achieve objectives; improved communication with stakeholders including superiors; creation of a strategic plan to implement CCHD screening and leveraging team strengths to achieve the objectives	Education of hospital staff through webinars & continuing education events; public notified of screenings through a press release, a segment on the local news, and through publication of emergency regulations mandating screening; hospitals are now reporting screening results through an online database; brochure developed; website with resources for parents and providers	Move into the surveillance and quality assurance phase of the project; goals focus on assuring appropriate screening and follow up of infants with abnormal screens, and evaluating the efficacy of the program over the coming year; long term, ensure universal screenings

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
LA County, CA	Department of Public Health; volunteer agencies; Primary Care Healthcenter Association; and Medical Reserve Corps	Emergency preparedness in LA County; focus on community participation in planning for response and recovery	Develop a new "Community Resilience" focus to emergency preparedness emphasizing community participation in planning for response and recovery; development of toolkit containing concepts and training to increase Community Resilience; implement and evaluate Toolkit in 8 pilot project communities	The team leveraged the leadership tools and skills provided throughout the NLAPH program by coordinating disparate Workgroup objectives and Toolkit components into a comprehensive set of activities contained in a "Blueprint for Community Resilience"	8 pilot community coalitions on board; creation of a "Blueprint for Building Community Resilience" for the facilitation of completion and documentation of specific activities using concepts presented in the Community Resilience Toolkit; Planning for future resilience-building community activities	Support project implementation in pilot communities and work with coalitions to troubleshoot challenges; continue to promote multisectoral engagement; assure more structured community participation in leadership
Maricopa County - Preparedness	Maricopa Integrated Health System; Maricopa County; Maricopa Co. Dept of Public Health; Phoenix Fire Dept, Homeland Defense Bureau	Collaborative emergency preparedness and resiliency	Facilitate relationship building between diverse health care agencies, preparedness community, and community at large to develop resilient healthcare community	The team gained a greater understanding of the dynamics within complex organizations and additional practical experience with leadership theories and methodologies	Restructuring of AZCHER Central Leadership and Functional Groups to enhance the ability to include and engage additional partners; conducted workshops with several association partners to engage members; meet and greets to invite new members to the coalition	Continue regular meetings to engage members; focus on communication processes and flows for response and recovery efforts; identify gaps for future work; development of Guiding Principles to be used to focus direction of process
Martinsville, VA	YMCA; Piedmont Community Services; Virginia Department of Health; West Piedmont Health District	Health education, promotion of healthy lifestyles & health behaviors	Incorporation of 40 protective developmental experiences and qualities of young people into school curriculum to promote good-decision making	N/A	Canvassed community to gauge interest; established partnerships and gained approval from local schools and health agencies; teaching trainer contacted and teachers were trained	Continue to work with partners; complete pilot program; expand program for 2013-2014

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
Blue Island, IL	Blue Island Community Health Coalition; MetroSouth Medical Center; City of Blue Island; Blue Island Salvation Army Crossgenerations Corps Community Center	Adoption of evidence-based obesity prevention programs	Launch of the Blue Island Healthy Community Program to address the obesity epidemic for 25,000 residents in an underserved suburb of Chicago	Gained valuable insight on empowerment, commitment, team building and experienced moments of self-discovery; the team engaged in a targeted recruitment strategy, welcoming key stakeholders from state and county health departments and faith-based institutions to the coalition. Conflict resolution was expanded upon by exploring leading by listening techniques, public speaking with connectivity, and change management	Development of a community coalition; a new partnership was developed with the American Heart Association to pilot an innovative hypertension project aimed to build awareness about heart disease; the coalition will work with a federal health agency to film a short documentary on local health improvement efforts	Continuing to advance common goal of becoming a national model for community health

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
<p>Stark County (Canton), OH</p>	<p>Mental Health and Recovery Services Board of Stark County; Quest Recovery and Prevention Services; The Employment Source; University of Mount Union</p>	<p>Prevention of high risk alcohol use and misuse of prescription medications with a focus on opiates in young adults</p>	<p>Adoption of a model of influence to leverage shared ownership of the cause; empowering the coalition to shape the collective identity by helping stakeholders build a common focus</p>	<p>A collective leadership approach developed to focus on self- and other-awareness; understanding of the meta-space of the work and role of leadership; filling gaps for the community; understanding of change management leadership; a collective identity shaped with realization of the bigger picture</p>	<p>Coalition attends trainings and educational events and supports community awareness and cultural competency; launching of aggressive marketing and social media campaign to build capacity and assess community; held health fairs, town hall meetings, educational events, college presentations, set up Facebook and a mobile website and deployed survey research</p>	<p>Reinforce value of coalition by adding partnerships; look to millennials to lead work; develop logic model for the development of a comprehensive strategic plan</p>
<p>CA (Statewide)</p>	<p>Public Health Institute; California Department of Public Health, Office of Health Equity</p>	<p>Use of the Health in All Policies approach to support the economic, physical, social, and service environments to promote opportunities for health and support healthy behaviors.</p>	<p>Promote health equity through the HiAP Task Force; provide leadership and help build the capacity of the Office of Health Equity</p>	<p>Facilitation of team cohesion and enhanced ability to be effective leaders; exploration of different leadership styles; taking on new leadership challenges during period of institutional transition</p>	<p>Development of summary document of Task Force agency approaches to health equity; equity lunch and learns for OHE staff; development of common language around health equity for OHE</p>	<p>Define capacity building needs and establish vision for team; support CDPH and OHE in efforts to advance health equity; support HiAP Task Force to define shared goals and establish a common vision for promoting equity; develop a plan to support local health departments in their application of a Health in All Policies approach</p>

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
Atlanta, GA	County Department of Health and Wellness; Air Allergen and Mold Testing Inc.; Rite Aid Pharmacy, Zap Asthma	Improvement of indoor air quality and asthma medical treatment in at-risk populations	Enhance the capacity of the Fulton County Department of Health to deliver quality asthma education sessions by partnering with other community organizations	Learned ways to keep the team moving and maintain focus on the big picture; learned that change happens faster when there is buy in from team members; understanding of gaps in leadership styles and ways to improve	Created steering committee with mission statement and governing principles; defined metrics; researched/presented relevant studies for decision-making; selected action and supporting action areas; collaborated with local hospitals, State Asthma Control, Atl Housing Authority, DHHS, Atlanta Apartment Association; Governmental Affairs; city leaders and others; developed action plan for groups for resources and education; initiated media and print ad campaign; created medial action committee	Continue the prioritization of four strategies 1. airborne triggers; 2. surface triggers; 3. humidity control; and 4. medical treatment and alternatives

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
Wilson, MI (Hannahville)	Hannahville Health Center; Nah Tah Wahsh Public School Academy; Keepers of the Future Childcare Center	Childhood obesity prevention in child care settings	Focus on identifying and implementing ways to make the childcare center a healthier environment for children.	Development of a key partnership between the Hannahville Health Center, the Nah Tah Wahsh Public School Academy, and the Keepers of the Future Childcare Center (all on the reservation)	Dietitian worked with the school kitchen staff to modify the menu to provide healthier foods, and more fruits and vegetables for snacks; education provided to children weekly focusing on making healthier food choices and using the USDA MyPlate as a guideline for eating; acquisition of MyPlate dinnerware for the children to use at meals, and appropriate portions are modeled at mealtime	Continue to focus on making environmental changes; work on breastfeeding policy in community workplaces; expand partnerships with local programs to improve access to healthy foods and safe play areas; work with the local health department to obtain playground equipment for the community; partner with Johns Hopkins University to improve access to healthy foods in local stores; work with tribal leaders to change community policies
Panhandle Nebraska	Panhandle PH District; Western Community Health Resources; Community Action Partnership of W. Nebraska; Rural Nebraska Healthcare Network	Healthy eating, active living and healthy weight across the lifespan	Develop a core group of leaders who serve as change agents working through community health improvement by assessing, planning, identifying strategies and evaluating effectiveness	Understanding of the importance of working through conflict to arrive at best solutions; looking at long-term planning with diverse stakeholders; clarity about what consensus wishes to achieve long-term	Identified and discussed relevant studies regarding asthma	Completion of project website; maintain leadership relationships, meetings and learn from one another on a quarterly basis

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
Connecticut	Connecticut Hospital Association; Community Health Centers, Inc.; Uncas Health District; Connecticut Department of Public Health	Policy and systems change for the improvement of maternal and infant health	Establishment and organization of coalitions to effect policy and systems change	Creation of core team with enhanced leadership skills to navigate siloed a public health environment	The team planned, recruited participants and convened a countywide coalition of advocates with an interest in maternal and infant health; over 25 participants attended the meeting from a wide range of sectors; Development of Resource Guide for Maternal and Infant Health	Continuation of work in New London County and formation of a pipeline of communication between the state and county on the topic of maternal and infant health; replication of process to create similar countywide initiatives across the state; creation of statewide coalition working towards policy and systems change to improve poor birth outcomes
Osceola County, FL	Osceola County Health Department; Osceola County Community Vision; Florida Hospital; Health Council of East Central Florida	Improve health access and outcomes for residents with chronic medical conditions	Development of a program to identify citizens in need of a medical home; use of a patient navigator to provide outreach and health education to ensure patients are connected to a medical home and social services	Applied concepts of systems change, collaboration, relationship building with partners and stakeholder and engaged stakeholders in a shared vision for improving health access	EMS became a partner in planning; key stakeholders identified; patient navigator system approved; target population identified	Site visits and learning from fire department operating "para-medicine" program; working with attorneys, identify legal hurdles to program; hire patient navigator

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
Nassau County - SIDS	Stony Brook University School of Medicine; Nassau County Department of Social Services; Northshore - LIJ Health System	Child fatality; sudden infant death syndrome	Process of conducting a needs assessment of birthing hospitals; formation of work group based on needs identified	Development of an understanding of policies from each members' discipline and review evidence-based practice models; identification of key stakeholders; improve tracking of progress; critical reflections on leadership skills; clarification of partners; navigation of challenges; management of conflict	Inclusion of six county birthing hospitals; information gathering process begun with questionnaires administered in local hospitals	Identify gaps/needs from assessment; further engage stakeholders; form workgroups with key stakeholders; team member become ambassadors for preventing SIDS; engage CFRT; build trust with agencies; assess feasibility of installation of safe sleep demonstration corner
Burlington County, NJ	Burlington County Health Department; Virtua Community Nursing Service; College of New Jersey	Reduction of child exposure to lead hazards	Creation of a primary prevention method using GIS mapping to eliminate childhood lead poisoning children in Burlington County, NJ	N/A	N/A	Use of GIS mapping strategy as primary prevention technique to prevent lead poisoning in children across the US; adoption of CDC actionable threshold for lead to 5 micrograms/dL in NJ

Team Site	Team background	Public health focus	Project description	Key leadership achievements	Key project achievements	Future goals and needs/ plans
Louisiana (Statewide)	LA Hospital Association; LA Office of Public Health; LA Rural Health Association; LA Public Health Institute	Align and leverage Louisiana community health improvement efforts	Increase collaboration to align and leverage LA community health improvement efforts by engaging and maintaining communication among key partners and the state and community levels	Development of meaningful working relationships and succeeded in engaging constituents and other key partner. The team developed a shared vision for the process and project goals aligning with individual organization agendas and realistic expectations	Conducted CTG community health assessments; increased collaboration with local partners; utilizing the MAPP process developed phased strategic planning to improve public health and implement a community-owned strategic plan; completed statewide assessment including multi-sectoral participants; collected feedback from communities; identified community resources and assets	Continue to host bi-monthly CHI partner conference calls to identify and expand strategic partnerships and key programmatic focus areas

Appendix K: Recommendations from Participants

The following is a summary of recommendations that participants included as part of the follow-up assessment.

Q: Are there leadership topics you wish the Academy had emphasized in greater depth, or areas that were not covered but that you feel are important for intersectoral health leaders?

Survey responses: n=20

- How to's for pushing boundaries and getting people to work outside of siloes (2)
- Strategies to engage community and local state government health agencies (1)
- Tools and resources for collecting/using data (2)
- Visioning/goal setting (2)
- Clarification of theories of leadership and practical application (1)
- Ethics in decision-making and resource allocation (1)
- Policy, systems, and environmental change (1)
- "Managing-up" (1)

Q: Do you have any specific recommendations for how the NLAPH could better support the development of intersectoral leadership for community health improvement?

Participants offered suggestions for how NLAPH could better support the development of intersectoral leadership and also provided general program recommendations (n=36). A number of NLAPH participants (n=12) commented on the need for more networking opportunities within the NLAPH program. Suggestions included the need for a culminating event where teams met in person to share their project milestones, challenges and successes. Other participants offered suggestions for conducting small, regional NLAPH mid-year meetings, including coaches, to be able to connect to local networks. A few participants recommended that teams are matched with other teams for peer learning opportunities and to encourage regular phone calls to update one another on progress.

- "Recommend that there be a mid-year gathering of local NLAPH representatives to discuss how they are progressing, what set-backs they may be encountering as well as allow them to share their motivation and re-energize with colleagues of similar backgrounds."
- "Do more networking at the national gathering. Don't have us spend so much time in our own team groups. Match teams together in pairs so we have a partner team that we work with, perhaps throughout the year. We could

commit to a monthly call between the two teams to update each other on progress and struggles for example.”

- “...in instances where you can pair teams in the same region after the retreat, consider it. I love the use of technology but nothing supplants face-to-face interaction. I would have liked to see what my team mates were up to in North Jersey. My organization would have been happy to host at no cost.”
- “...there was not nearly enough time to learn from peers. I didn’t get to meet or talk to other teams at all. It might be nice to match groups to do some peer learning (or something). I felt like we could have benefited much more from each other.”
- “A retreat at the end of our project work would have brought us back together to present our projects and learn from one another. This would have enlarged the national network... if there is not sufficient funding for a retreat at the front end I would recommend our coach visit and work with us in a day-long retreat locally and then bring the teams together at the end so we can talk through challenges and what worked.”

A number of participants recommended that the role of the coach be expanded to include more in-person visits; a few commented on the recommendation of including one-on-one visits with each team member (n=8).

- “I would like to see more time in person with the coaches. We had excellent meetings with our coach at the retreat and during his visit, but another visit or another way of touching base, maybe even an individual meeting with each team member would have been helpful.”
- “Our mentor was very helpful and perhaps more time with the mentor would also focus us. Another consideration: individual time with the mentor would have helped me brainstorm about ways to confront the team members who did very little.”

Q: Do you have any specific recommendations for how the NLAPH could best support Academy graduates in continuing their intersectoral leadership development beyond the program year?

A number of participants (n=11) suggested that the continued availability of webinars to NLAPH graduates would be an appreciated resource. Responses indicated that archived, recorded, and live webinars would be of value to graduates.

- “If any of the webinars might differ from the ones offered to us it might contribute to our continued education to be allowed to attend the webinars. Also, perhaps an annual webinar for alumni for continuing education might be offered...”
- “Please continue to give us access to webinars – live and archived.”
- “If you could bring us back together again now that we are deeply in engaged in projects relationships could be forged for the future.”
- “Bring a couple of teams back to the Atlanta retreat to discuss their projects an to glean further insight into where the project should go.”

Participants (n=7) commented that they would like additional opportunities to meet with other NLAPH participants either regionally or at a national meeting. Most individuals who made this recommendation commented that the program would have been well-served to have a culminating meeting of all participants.

- “Coming back together as a whole group would be an option to share successes, learning curves etc. but that would also be more impactful if we had more connections with the other groups.”
- “If you could bring us back together again now that we are deeply engaged in projects, relationships could be forged for the future.”
- “I would have liked to have seen at least a one day summarization retreat for sharing and closure. The short closing presentations did not give us the opportunity to really share all of our accomplishments with our colleagues.”

Participants (n=8) recommend that resources and learning materials continue to be available. A number requested this via an online portal such as phConnect or LinkedIN; others would like to see a binder of materials. A number of participants shared that phConnect was not a user friendly resource and they would like to see this improved (n=2).

- “A curriculum binder full of resources and tools.”
- “Keep resources available (phConnect). Send updates on new or relevant information that may be helpful for leadership development.”
- “I would like an online community for alumni where webinars, readings, updates on projects, new projects and opportunities for Q&A can be offered.”

Participants (n=6) commented on wanting for NLAPH to formally continue the mentoring program for some time after the conclusion of the program year.

- “Continue the mentoring programs with set check in calls for updates and reminders...”
- “Make mentors from program year available on a continued basis.”
- “Having specific set times to follow-up with coaches, even if it were only quarterly for the first year following graduation.”

Participants recommend that NLAPH follow-up with teams to request updates (n=6).

- “I feel that there should be some sort “down the line” or “near future” follow-ups; otherwise loads of money and time spent educating and mentoring from NLAPH leadership with no concrete data for support of continuation of Academy in future.”
- “Follow-up questionnaire in 6 months and 1 year, reaching out to each to team to see how they are progressing.”

Participants recommended that NLAPH graduates serve as peer mentors or be engaged in some capacity with the future NLAPH Academy (n=2).

- “The best way to support us is to invite a member or members of each of the first 20 teams to future retreats and assign them teams much like the coaches so they may act as peer mentors...”
- “Include us in webinars/discussion/conference calls with new participants.”

Center for Community Health and Evaluation

1730 Minor Ave, Suite 1600

Seattle, WA 98101

(206) 287-4389

www.cche.org