CENTER FOR THE HEALTH PROFESSIONS
RESEARCH BRIEF

Leadership in Action: The Role and Impact of the CHCF Health Care Leadership Program's California Health Improvement Project (CHIP)

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ABSTRACT

This report provides an overview of the CHCF Health Care Leadership Program and a summary of results from an assessment of the process and impact of a key component of the program, the California Health Improvement Project (CHIP). CHIPs are leadership projects undertaken by program participants at their home organization. Areas of impact resulting from the CHIPs, dissemination activities, and factors that contributed to the successful implementation of the CHIPs from the perspective of program alumni are described. Ongoing enhancements to the CHIP component of the program are also discussed.

Introduction

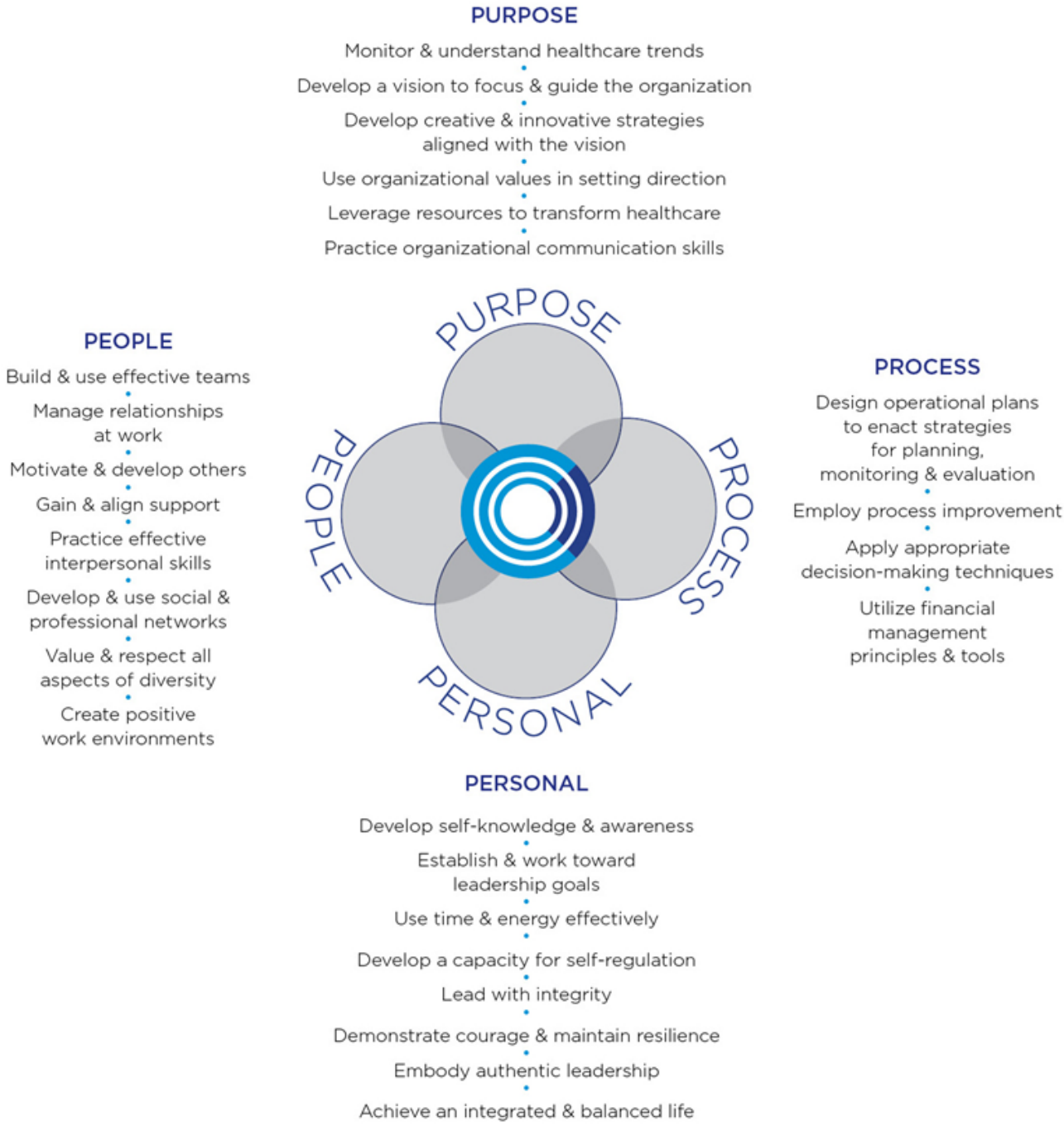
The California HealthCare Foundation (CHCF) Health Care Leadership Program launched in 2001 to prepare clinically trained health care professionals to lead California's health delivery organizations and to create a network of strong, effective leaders to provide mutual support for improving health care for all Californians. In the program's second decade, this long-term investment in leadership development, coupled with the active cultivation and use of its alumni network, serves as a resource for health care change at the individual, organizational, regional, and statewide levels. A key component of the program is the California Health Improvement Project (CHIP), which provides each fellow an opportunity to apply newly acquired skills to improve care in their home organization. This report describes the CHCF Health Care Leadership Program and discusses the role and impact of the CHIP over seven cohorts of the program.

Program Overview

The program is a part-time, two-year fellowship directed by the Center for Health Professions (Center) at the University of California, San Francisco. Each cohort consists of 30 individuals who are selected through a competitive application process. Program participants are required to be clinical health professionals with five or more years of leadership experience. In their application to the program they must demonstrate professional or civic accomplishments and show a strong commitment to rigorous engagement of the challenges confronting health care in California. Each participant must also be endorsed by his or her home organization as a future leader.

The fellowship is grounded in the Center's competency-based leadership model, which consists of four interlinked domains – purpose, process, people, and personal. Each domain consists of a set of distinct leadership competencies (see Figure 1).

Figure 1: Competency-Based Leadership Model



The Center's competency-based leadership model underpins the program elements (see Table 1). Through these learning activities, the participants' leadership knowledge and skills are reinforced and strengthened to increase participants' ability to lead change in their organizations. The program emphasizes interactive content, and uses different teaching modalities and settings with multiple feedback loops to better allow for program and participant improvement.

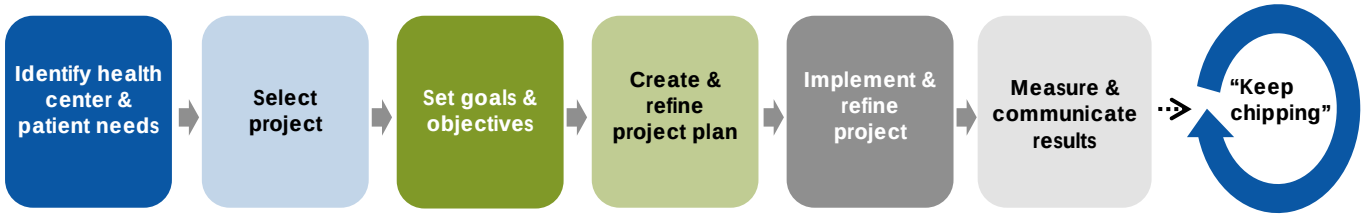
Table 1: CHCF Health Care Leadership Program Elements

Program Element	Detail
Seminars	Six, 4-day seminars that include didactic teaching, case studies, peer learning, and other interactive instruction methods.
Intersession Activities	Readings and case studies, peer group ("pod") interactions, telephone and web conferences, and completion of web-based tools to track development and to share progress with others.
Pod Groups	Regional groups of 4-6 fellows with an assigned advisor that provide support, feedback, and learning opportunities as fellows move through the program.
Coaching	Five hours of individual executive development coaching.
CHIP	A leadership project each fellow completes at their home organization on a topic of their choice following program guidelines.

California Health Improvement Project (CHIP)

In the course of the CHCF Health Care Leadership program, each participant undertakes a leadership project at their home organization known in the program as the California Health Improvement Project, or CHIP. During the first six months of the program, fellows develop the goals and objectives for their projects with the input of program faculty and staff. The CHIP must address a timely issue or challenge facing participants' organizations. The CHIP illustrates how the program facilitates organizational change and improvement and provides a hands-on change management experience that both improves and demonstrates participants' learning over the course of the program. Each proposed project is reviewed and assessed by program faculty, other fellows, and leaders within the home organizations. Fellows receive feedback in small groups, within their program cohort of 30 and from members of the larger alumni network of previously graduated fellows. The figure below provides an overview of the CHIP process.

Figure 2: Overview of the CHIP Process



Impact of the CHIP

In September 2010, we asked the 200 alumni for whom we had current contact information to complete an online survey about their CHIP projects and their experiences with the CHIP process. The response rate was 62% (n=124) with slightly higher participation among more recent cohorts. Table 2 summarizes select demographics of the respondents, which are representative of the demographics of program participants overall.

Table 2: Select Characteristics of Survey Respondents

Characteristic	Percent of Respondents (N)
Gender	
Female	54.8% (68)
Male	45.2% (56)
Race/Ethnicity	
African American	4.0% (5)
Asian/Asian American	0.8% (1)
Caucasian	69.4% (86)
Hispanic/Latino	20.2% (25)
Native Hawaiian/Pacific Islander	2.4% (3)
Other	0.8% (1)
Unknown	2.4% (3)
Profession	
Dentistry	4.0% (5)
Dietetics	0.8% (1)
Medicine	69.4% (86)
Nursing	20.2% (25)
Pharmacy	2.4% (3)
Physical Therapy	0.8% (1)
Social Work	2.4% (3)
Type of organization	
Academic Institution	12.1% (15)
Community Clinic or Health Center	14.5% (18)
Government	10.5% (13)
Health Plan or Managed Care Organization	9.7% (12)
Public Hospital or Health System	16.9% (21)
Private Hospital or Health system	11.3% (14)
Private Practice	11.3% (14)
All Others*	13.7% (17)

*Includes community organizations, consulting groups and others.

The geographic distribution of survey respondents is also aligned with that of program participants overall. Roughly 40% (n=49) and 32% (n=40) of respondents reside in the Bay Area and the Greater Los Angeles/San Diego Area, respectively, with the remaining respondents living across the Central Valley, Central Coast, and Far North.

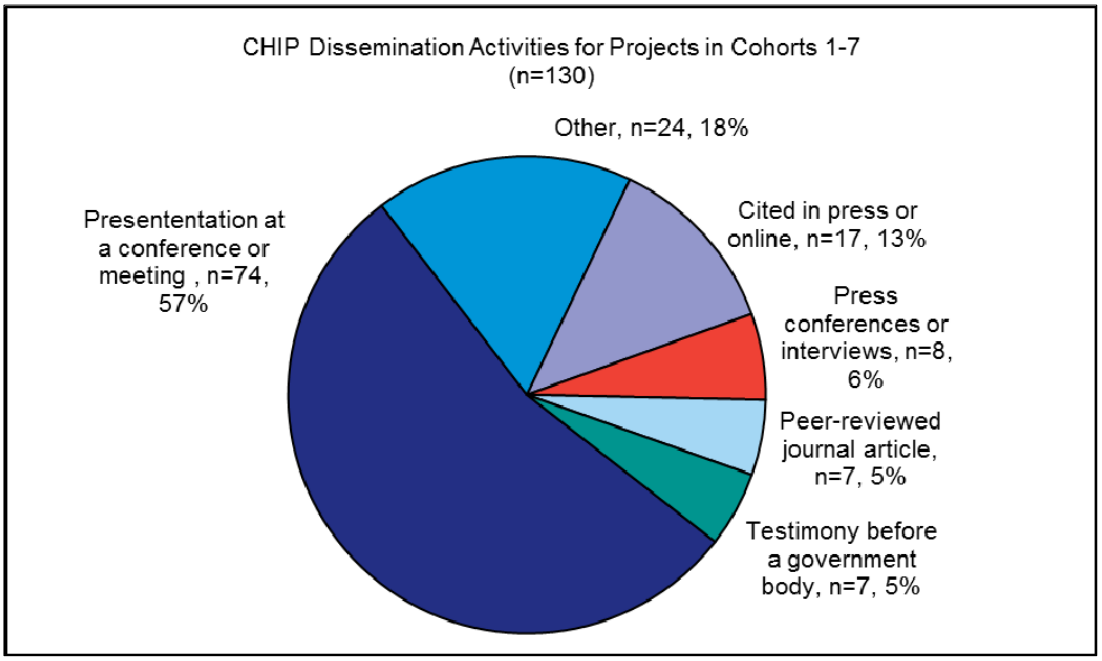
To better understand the impact of the CHIP, respondents were asked to categorize the focus of their CHIP into four possible areas of impact. The four areas of impact available were financial, people, service, and quality.[1] Quality was the most frequently (31%, n=42) selected area, followed by service (28%, n=38), people (23%, n=32), and financial (18%, n=24). Alumni could choose more than one area, thus the total responses exceed the number of respondents.

We also assessed the CHIP impact of by asking alumni about dissemination of their project results. Respondents were asked to indicate if they engaged in one or more of the following activities:

1) presentations at meetings or conferences, 2) giving testimony at local, state, or federal government hearings, 3) holding press conferences or giving radio interviews, 4) being cited in a newspaper or on a website, and 5) being published in a peer-reviewed publication. They were also able to choose "other" and include written comments about their dissemination activities.

As seen in Figure 3 below, the most frequently reported activity was presentation at meetings or conferences. This was followed closely by "other," which included reporting results within the organization and to funders and developing written manuals, guidelines, or procedures for internal use. Fellows infrequently reported using the other dissemination activities. In each cohort year, a large majority of participants were successful in disseminating their project work through some selection of these channels.

Figure 3: Dissemination Activities for Projects for Cohorts 1-7



Because the CHIPs are developed in cooperation with the fellows' home organizations, the CHCF Health Leadership program was also interested in determining the degree to which the program played a role in implementation of the CHIP. Survey respondents were asked to indicate how likely they were to have undertaken their CHIP without the CHCF Leadership program. Responses were split almost evenly, with 51% (n=58) indicating that they were unlikely or very unlikely to have undertaken the project without the impetus of the program. Many respondents noted in qualitative responses that while they may have undertaken their project, the project implementation was smoother or easier with the help of the program. For example, one respondent stated, "Although I would have likely taken on the project, it would not have been as successful without the process of the CHIP."

CHIP Process

The survey asked respondents to identify one or more factors that contributed to the successful implementation of their project (See Table 3). A majority of respondents most frequently indicated that engaged organizational

stakeholders and support from executive leadership contributed to their ability to successfully implement their CHIP.

Table 4: Factors contributing to successful implementation

Factors	Percent of respondents † (N)
Engaged key stakeholders	66% (82)
Executive leadership support	53% (66)
Institutional support	37% (46)
Program peers	37% (46)
Staff support	30% (37)
Coaching/mentoring	29% (36)
Technology	20% (25)

† Respondents could select more than one factor, therefore total exceeds 124.

In qualitative responses, respondents also referenced the strength of the CHCF network and the alignment of CHIP goals with changes coinciding in the broader political environment as important factors that contributed to their success. In addition, being provided with a structured process for implementing change was also viewed as integral to the CHIP's effectiveness.

Across all cohorts, 60% (n=75) of respondents reported completing their CHIP prior to graduation from the program. An additional 15% (n=18) of fellows completed their CHIP after graduation, bringing the overall completion rate to 75%. Fifteen (12%) respondents did not complete their CHIP. Although 16 (13%) did not respond to the question of whether the CHIP was completed after graduation, all 15 of the respondents who did not complete their CHIP after program completion and all 16 respondents who did not answer the question indicated that they had continued to work on their CHIP after the program ended. Program staff are aware that CHIP completion can be impacted by participant job changes, changes in the funding environment, and other external factors such as policy changes at the state or national levels. Significantly, 80% (n=100) of respondents indicated that some aspect of their CHIP had been sustained or expanded within their own original home organization or outside at another organization after completion of the fellowship, signifying the value and relevance of the projects.

Conclusion

The CHCF Health Care Leadership Program has an ambitious goal of improving the health care system for all Californians by developing individual leaders and creating a statewide leadership network. This robust network, currently consisting of nearly 300 alumni representing a variety of clinical backgrounds and health care delivery organizations, has facilitated successful collaborations among health care leaders across the state.

The knowledge and skills taught under the Center's Leadership Model in the two-year CHCF Health Care Leadership Program are reinforced and strengthened through a variety of learning activities. One of the most integral learning activities is the California Healthcare Improvement Project (CHIP). The CHIP serves not only as

an exercise in project management and organizational improvement, but as a vehicle allowing each fellow to apply specific leadership skills and lessons learned within a supportive and collegial framework while implementing real changes that improve health care delivery.

Since the time of this survey effort, the program has identified ways to strengthen the CHIP component of the fellows' leadership development. In recent cohorts, fellows have been encouraged to select and implement a project that is aligned with the Institute for Healthcare Improvement (IHI) triple aim: Improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care.[2] Increased emphasis has also been placed on measuring and reporting additional robust outcomes, including financial data. Going forward, these rigorous project metrics will further demonstrate the impact of the CHIPs both within individual projects and across cohorts.

During the first seven cohorts of the program, the CHIPs resulted in organizational and system-wide changes. The outcomes and lessons learned from the CHIPs were widely disseminated within the fellow's home organizations and throughout CHCF Health Care Leadership Program network. With ongoing refinements to the program, the CHIPs will continue to spur important change, making lasting impacts on fellows' organizations and on the broader health care system.

Acknowledgements

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References

1. Studer, Q. (2004). *Hardwiring Excellence: Purpose Worthwhile Work Making a Difference*. Gulf Breeze, FL: Fire Starter Publishing.
2. Institute for Healthcare Improvement. Available from: http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx.