Chapter

Clinical Scholars: Making Equity, Diversity and Inclusion Learning an Integral Part of Leadership Development

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Abstract

The plethora of persistent and pervasive health inequities in the United States is a Wicked Problem which threatens the health and wellbeing of all people. To dismantle them is no easy task, and requires a health care workforce practiced in leadership skill sets embracing a deep focus on areas of equity, diversity and inclusion (EDI). This chapter describes how the core competencies and curriculum of the Clinical Scholars Program have been designed to offer this set of skills. To start, the program's foundational set of 25 competencies cover four domains (Personal, Interpersonal, Organizational, and Community & Systems) and include both more traditional leadership competencies as well as contemporary competencies focused on equity, diversity, and inclusion. The curriculum takes the set of 25 leadership and EDI competencies and breaks them down into learning sessions where participants listen, practice, and apply the ideas, behaviors, and mindsets. The leadership core and the EDI core of the curriculum exist both in tandem and in unison to provide the full Clinical Scholars experience. At times, sessions focus on one core or the other, and at times, both leadership and EDI are present in the learning of a session. Example learning sessions for each core and the weaving of the cores together are provided. Four challenges to creating an equity-centered leadership program are identified: 1. The personalized nature of the journey of self-development; 2. Shifting Mindsets and Skill Sets; 3. Piloting an evidence-based curriculum on EDI; and 4. Maintaining engagement with participants over time and across distance. A set of top recommendations for weaving EDI and Leadership learning are also offered. The chapter details the importance of meaningfully focusing on EDI when tackling modern, wicked problems.

Keywords: equity, diversity, leadership development, competencies, curriculum, workforce development, culture of health, leadership

1. Introduction

In their 1973 article, Rittel and Webber introduced the idea of 'wicked problems' [1]. They described wicked problems as being ill-defined, without clear explanation for their existence or clear solution for their eradication. They differentiate these

problems from more "benign" problems by explaining that wicked problems are malignant, socially complex, and impacted by multiple systems. Benign problems—though they may be difficult—can be clearly solved with tools we have at the ready. Wicked problems are those we have no identified solutions for, that have no ready-made fix, instead they require a new combination of tools and skills to successfully tackle them [1]. Poverty, climate change, food security, and the balance between technological advance and personal privacy are all examples of wicked problems.

Decades later, in 1998, Ronald Heifetz introduced the concept of "Adaptive Leadership", which, over subsequent decades, grew into a predominant framework for applying leadership to intractable problems [2–4]. This framework identifies "technical problems" as being separate from "adaptive problems", in which the solutions are unclear and require learning and mobilization of stakeholders to address. In the adaptive leadership model, all parties must grow, adapt, and change as they learn new information and apply that learning to the challenge. Thus Adaptive Leadership does not rely on historical or pre-defined strategies to address these complex challenges, but rather recognizes that the strategies need to be developed through mutual understanding, collaboration, and often invention. Adaptive leadership strategies are useful in addressing wicked problems faced by society.

A wicked problem faced by our health and healthcare workforce—threatening the health and wellbeing of all people—is the plethora of persistent and pervasive health inequities in the United States. These inequities begin at birth—starting with which babies are more likely to be carried to term and celebrate their first birthday [5–8] —and continue compounding through a person's life. For example, we know there are differences in which patients receive treatment for health problems and what treatment options they receive [9–14], and the literature indicates that a person's zip code is an important predictor of the length and the quality of their life [15–17]. These inequities are rooted in historic policies, continued through current-day operation of our social systems and institutions, and perpetuated by the myth that responsibility for an individual's health outcomes lies solely within that individual's sphere of control. While these inequities are not solely created within the health care system, the health and health care workforce has particular responsibility and opportunity to address them.

Like other wicked problems, there is no easy fix, no magic bean, and no one-size-fits-all solution for the policies, practices, and biases that cause and perpetuate health inequities. To dismantle them requires a health care workforce practiced in leadership skill sets embracing a deep focus on areas of equity, diversity and inclusion (EDI).

The Clinical Scholars National Leadership Institute (CSNLI, online at ClinicalScholarsNLI.org), known more broadly as Clinical Scholars (CS) or the Clinical Scholars Program, is a leadership development experience for clinician leaders that weaves the concepts of leadership, equity, diversity and inclusion together in a three year, robust curriculum. The mission of the program is to "*develop adaptive leaders from all health disciplines to extend their influence and impact through transformative leadership training centered in equity, diversity, and inclusion*." At the heart, the Clinical Scholars Program teaches adaptive leadership strategies to health care professionals so they may have positive influence on the wicked problem of persistent health inequities in their communities and across the span of their careers.

While Chapter 1 of this book describes the overall pedagogy of the Clinical Scholars Program, this chapter describes how the program's core competencies and curriculum have been designed to develop a health care workforce with the skills needed to take on these wicked problems. It details the creation of this content and its intentional formats, challenges that emerged in the process, and the importance of meaningfully focusing on EDI when tackling modern, wicked problems.

2. A call for something more

In 2009, the Center for Creative Leadership (CCL) announced a shift in their leadership development focus towards the idea of "Boundary Spanning Leadership", characterizing it as *"the capability to create direction, alignment, and commitment across boundaries in service of a higher vision or goal."* [18]. CCL found five categories of boundaries in their research that leaders need to be able to span to address today's evolving challenges: vertical, horizontal, stakeholder, demographic, and geographic. Similarly, in 2013, leadership development experts at the University of North Carolina's Gillings School of Global Public Health wrote about the role of public health and health care providers serving as "boundary spanning leaders" [19] and published the outcomes of programs focused on training leaders in these skill sets [20–23]. More recently, the de Beaumont Foundation, along with partners in the public health field, released the report, *Building Skills for a More Strategic Health Workforce: A Call to Action* [24]. In the report, they identify eight domains of "Strategic Skills" the health workforce needs to invest in to address the complex problems currently in front of us: systems thinking; change management; persuasive communication; data analytics; problem solving; diversity and inclusion; resource management; and, policy engagement. Collectively, these bodies of work are suggesting a critical shift— the need to move beyond trying to address *wicked* problems with solutions intended to solve benign ones. To make this shift, we need leaders who have the skill set and the mindset to develop new solutions that better match these wicked problems.

So what would leadership development designed for such leaders actually look like? In Clinical Scholars, our charge is to create and support networks of visionary leaders who can break down silos, tackle the root causes of health inequities, and lead in a rapidly evolving landscape. We have created a program that supports our participants, referred to as "Fellows", to change the culture of health in their communities by building bridges between public health, health care and other systems that have enormous influence on an individual's well-being and their opportunity to be healthy—education, neighborhoods, transportation, income, faith, and others. We have developed a curriculum to help these leaders transform culture at every level, putting health and equity at the core. Clinical Scholars does this by challenging traditional ideas of leaders and conventional teachings in leadership development programs to include concepts of EDI as integral to the concept of leadership itself.

For Clinical Scholars, equity, diversity and inclusion are more than buzz words spoken at a boardroom table. They are concepts ingrained into the fibers of our program. We define *Equity* as the fair provision and distribution of resources and power so all people may realize their full potential. To reach equity means we have eliminated privilege and advantage of historically included groups, and the oppression, disparities, and disadvantages of historically excluded groups (adapted from CommonHealth ACTION, VISIONS) [25, 26]. We see *diversity* as the representation and mix of identities, differences, and similarities, both collectively and as individuals. These differences may include race, ethnicity, gender identity, disability, sexual orientation, socio-economic status, personal historical experiences, philosophical approaches and paradigms, among others (adapted from CommonHealth ACTION, Ford Foundation, VISIONS) [25–27]. *Inclusion* is the conceptual state by which all voices, perspectives, and people can contribute, be heard, and their talents utilized. It is not merely a seat at the table; it is full participation, engagement, and belonging (adapted from CommonHealth ACTION, VISIONS) [25, 26].

What makes the Clinical Scholars Program unique is that while other leader and leadership development programs might give a nod to EDI through discreet session content, CS weaves EDI concepts into the entire curriculum, focusing on how to lead the diverse communities in which our clinician leaders live, grow,

work, play and pray. In other well-known executive leadership experiences, EDI curriculum is absent, optional, or lacks the robust integration needed for a more complete response to modern social complexities [28–30]. In CS, we recognize that a one-time conversation on cultural differences will not produce the change needed to address health care inequities; we set out to do better by our clinician leaders by preparing them with an integrated skill set to lead change in our current system of care. EDI is not just one of the competency focus areas, but is a foundational principle addressed alongside and equal to traditional leader development competencies. Clinicians in the CS Program receive equal emphasis on emotional intelligence and intercultural sensitivity, on managing difficult conversations and on addressing racism in communities, and on feedback using traditional leadership assessment tools and considering the power and equity dynamics at play in organizations. Our desired outcomes include graduates with the skill set and the mindset to approach their practice and their work within their community in more equitable ways and to challenge the paradigms they see that lead to inequity and health disparities. The program gives clinicians the knowledge and opportunity to recognize the systemic and institutional barriers and "-isms" which play a significant role in health outcomes, and to create innovative and community-oriented solutions for change.

3. Core competencies

In order to impart the nuanced and sophisticated skills needed to create a culture of health in communities, 25 leadership competencies stand at the core of the Clinical Scholars Program and stem from the overarching goals described in Chapter 1 of this book. The program groups these competencies into four domains: *Personal*, *Interpersonal*, *Organizational*, and *Community & Systems* (see **Figure 1**). Additionally, the competencies marry traditional leadership skill sets with contemporary skill sets in the areas of equity, diversity and inclusion.

To develop our complete list of 25 competencies the CS leadership team and partners from Community-Campus Partnerships for Health looked to institutions of higher learning and clinical practice to identify the most important behaviors and skills clinician leaders need to best address the wicked problems plaguing their

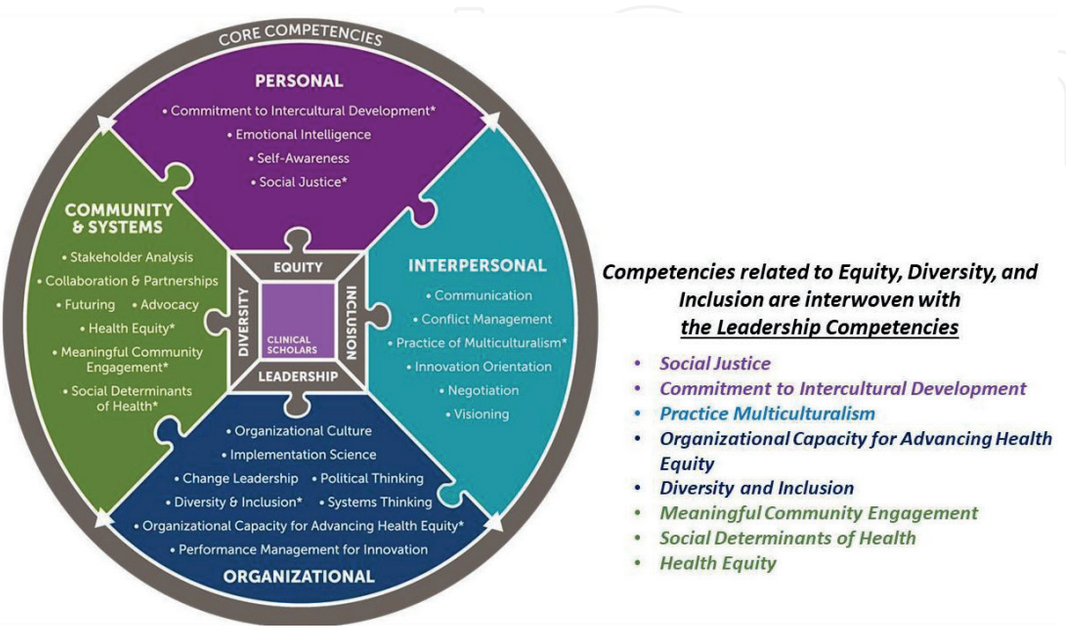

Figure 1.
The 25 Core competencies of the clinical scholars program.

communities. Those findings were combined with existing competency sets from other long-standing and successful leadership institutes, including the Maternal and Child Health Public Health Leadership Institute [20] the ACOG-Robert C. Cefalo Leadership Institute [22, 31], the Food Systems Leadership Institute [21], and the UNC Leadership for Neurodevelopmental Disabilities (LEND) program [32, 33]. Other competencies were culled from the literature on equity, diversity and inclusion, as well as from the work of national partners and organizations working on EDI in communities. The CS leadership team and partners reviewed and revised the existing core leadership competencies, added competencies specific to EDI core principles, and provided guiding definitions for each. (See Clinical Scholars Competencies and Definitions, Appendix A).

4. Curriculum

Over the course of the three-year program (See the pedagogical framework discussed in Chapter 1), participants are challenged to learn, try on, and then step fully into new and enhanced behaviors and mindsets that help them grow from being individual contributors into being leaders of teams, communities, and systems. To do this, the Clinical Scholars curriculum takes the set of 25 leadership and EDI competencies and breaks them down into learning sessions where participants listen, practice, and apply the ideas, behaviors, and mindsets. Session formats vary depending on the declared learning objectives. Formats utilized in the program include didactic lectures, small and large group discussions, case study debriefs, practice scenarios, and simulation experiences, among others.

A leadership core and an EDI core of the curriculum exist both in tandem and in unison to provide the full Clinical Scholars experience. At times, sessions focus on one core or the other, and at times, both leadership and EDI are present in the learning of a session. Here, we highlight the origins of each core curriculum alongside an example of that curriculum in action. One example is from our leadership core, one example illustrates our EDI core, and the third example shows how the cores come together to provide a deeply rich learning experience.

4.1 The leadership Core

Overall, the Clinical Scholars leadership core couples "hard skills" drawn from health services research, public and population health, engaged scholarship, health equity research, and cultural sociology with methods that develop individual and team "boundary-spanning leadership skills" shown to significantly impact participant development. Many of the sessions in the leadership core were adopted and adapted from other successful national leadership programs that illustrated significant participant learning [20–22, 31], encouraged interdisciplinary effectiveness, [32, 33] and showed real-world outcomes connected to projects undertaken as a part of the training [20, 21].

Leadership Core Example: *The Discovery Leadership Profile™.*

CS Competencies Covered:

- Change Leadership/Change Management
- Communication
- Emotional Intelligence
- Self-Awareness

The CS offers a total of up to 12 assessments to Fellows over the course of the three-year program (see Chapter 1). Many of these assessments address leadership core competencies. A prime example of the leadership curriculum and one of the most robust assessments in the program is a 360 assessment called the Discovery Leadership Profile (produced by Multi-Health Systems Inc.), which Fellows complete six months into the program. Long-standing components of leadership development programs, 360 assessments are multi-rater tools that gather feedback on key leadership areas. These assessments help identify strengths and developmental needs. Similar to other 360 tools, the Discovery Leadership Profile reflects standardized and validated questions around leadership. The assessment experience offers participants a full wrap-around experience of increasing awareness of one's self, and is paired with executive coaching in its debrief to foster improvement and personal advancement. To start the process, Fellows identify approximately 12–20 people that are above, across, and below them in the hierarchy of their organizations—along with community partners outside their organization as appropriate—who frequently see their leadership style in action. In a 80-minute session at the Orange Retreat (the second in the series of seven intensive in-person training programs, see Chapter 1), faculty explain the 360 tool, offer guidance on how to understand and interpret results, and provide reflection time for Fellows to digest what the results are telling them. Later in the retreat, following time to reflect and consider the meaning of the data, Fellows meet with an executive coach certified in the assessment to debrief and discuss their personal results. Coaches are charged with helping the participants move towards actionable behavioral changes that reflect their results.

4.2 The EDI Core

We believe that leadership development involves not only enhancing skill sets, but transforming mindsets as well. Too often, leadership programs fail to make lasting change in program participants. This happens when programs focus on changing behaviors that show up on the surface, but neglect to address the underlying mindset that explains the behavioral choices being made [34]. Addressing mindsets requires a new conversation about the root cause of current behavior. It requires uncovering and questioning the subconscious thought patterns and implicit bias each training participant comes into the program with. It requires offering a new lens from which to view the world. We see this challenge as being evident in equity, diversity and inclusion work.

The intention was set from the beginning: Clinical Scholars curriculum would incorporate knowledge, skills, attitudes, behaviors, and mindsets focused on EDI equally with those concentrated on more traditional leadership areas. While the leadership core of CS is based on decades of research focused on leadership and leadership development, the same historic body of knowledge in academic/scholarly literature is not available for EDI training and development, especially as a leadership skill. In our search of the literature and online curricula, we could not find a clear curriculum either with the integration of EDI and leadership content equally, or with a main focus on EDI with leadership as a subset of the content. You can find leadership development programs that provide isolated EDI content, but no publicly available curriculum weights EDI equally with leadership, or smoothly integrates the two together throughout the program.

A critical success factor in developing the program's combined content was an EDI curriculum retreat held early on in the program's tenure (July 2017). Participants of the retreat included the Clinical Scholars program development team, along with partners--Community-Campus Partnerships for Health,

Behavioral Impact Aims
• Engage in a personal EDI journey (e.g. see and address self-limiting behaviors)
• Recognize and interrupt 'isms' (e.g. understand historical context of privilege and oppression)
• Incorporate EDI into their Wicked Problem Impact Projects (e.g. intentionally integrate community perspectives)
• Use strategic skills for group and organization level change (e.g. conflict and negotiation skills in cross-cultural groups)
• Catalyze health equity change with communities (e.g. apply principles of authentic partnership)
• Influence public policy (e.g. understand nuts and bolts of public policy advocacy)

Table 1.
EDI behavioral impact aims of the clinical scholars National Leadership Institute.

VISIONS, Inc.--well versed in EDI training content and methodologies. Through a facilitated process, the group discussed their vision for what the EDI curriculum could look like, identified potential components for the curriculum and sources for those components, and created the beginnings of a library of high-quality, skill development-focused content. Two significant products of the retreat were: 1) a deep understanding of the desired behaviors, language, and techniques the program wanted participants to exhibit by the end (Behavioral Impact Aims), and 2) the first version of an evolving EDI Curriculum Map.

It was essential to understand at a deep level exactly what we hoped would be enduring take-aways around EDI when the Fellows graduated from the program. To that end, a facilitated discussion at the retreat began with critically examining the initial EDI competency set identified, and ended by achieving consensus around the following question: "*Given these competencies and our visions, at the end of year 3, what do we want Clinical Scholars to know, understand and do?*" The collective responses of the group fell into six categories (labeled Behavioral Impact Aims) and clarified the behaviors and developments we want to see in the Fellows upon their completion of the program (see **Table 1**).

The formation of an EDI curriculum map followed. By looking at the identified Behavioral Impact Aims and the EDI core competencies, retreat participants were able to develop suitable learning objectives to meet intended goals of the program. The map outlined which learning would take place at what point in the three-year curriculum. Conversations revolved around which skills were more foundational and which skills would add valuable layers to already understood concepts. The map also indicated which learning needed a face-to-face experience and which could be done through distance-methods.

EDI Core Example: *The Community Action Poverty Simulation.*

CS Competencies Covered:

- Advocacy
- Change Leadership/Change Management
- Commitment to Intercultural Development
- Communication
- Emotional Intelligence
- Organizational Capacity for Advancing Health Equity

- Organizational Culture
- Political Thinking
- Social Determinants of Health
- Social Justice
- Systems Thinking

Clinical Scholars layers EDI concepts over the course of the three-year program. A prime example of the EDI curriculum and one of the most robust experiential components of the curriculum is called "The Poverty Simulation," produced by the Missouri Community Action Network. In the Yellow Retreat (3rd in the in-person training series), participants explore the experience of "personal agency" through role-play of individuals living under conditions common to the working poor in a 4-hour simulation experience. Participants must navigate complex and conflicting family dynamics, unsympathetic workplace demands, and emergent neighborhood crises, along with compounding barriers caused by inadequate public systems (transportation, schools, healthcare, etc.). The simulation consists of several short "weeks" of experience from which participants report both significant stress and perceived accuracy in the imitation of the lives of the working poor. An extensive debrief of the session helps to further the objective lessons about how the social determinants of health play a significant role in an individual's health and regularly overpower personal agency under these conditions. The learning objectives for this session revolve around increasing appreciation of the effects of poverty and its impact on health equity, helping participants explore misconceptions of the experience of poverty, and identifying how the experience of poverty can impact the communities engaged by the Fellows' Wicked Problem Impact Project (WPIP).

4.3 Weaving the two cores

Overall, the CS curriculum can be seen as a piece of woven fabric. Simply-constructed woven fabrics are produced by interlacing two sets of thread with one another; the repeating pattern of interlacing is called the weave. In the CS Program the Leadership Core and the EDI Core are the sets of threads. As the curriculum draws each piece in, interlacing the threads together by building on, nesting with, and linking to other components, the weave of the fabric is made. In weaving fabric, both sets of thread are important to creating textile that is useful, performs well, and is pleasing the eye; the same is seen in the Clinical Scholars Curriculum. The two curriculum cores of leadership and EDI are equally important to the viability, lasting behavioral impact, and ultimately, the success of the program. While some Clinical Scholars sessions may focus more heavily on either traditional leadership or contemporary EDI competencies and skill sets, other sessions weave these threads together into complex and multifaceted learnings.

Weaving Example: *Applying an Equity Lens.*

CS Competencies Covered:

- Advocacy
- Change Leadership/Change Management
- Commitment to Intercultural Development

- Communication
- Organizational Capacity for Advancing Health Equity
- Organizational Culture
- Political Thinking
- Social Justice
- Systems Thinking

Health care systems and organizations can take a leadership role in ensuring that everyone has the opportunity to be healthy [35]. In particular, health care organizations have the ability to not only address health disparities directly at the point of care but also to influence the social and economic determinants that result in health disparities. The Institute for Healthcare Improvement (IHI) has developed a framework for health care organizations to promote health equity in the communities they serve [35]. There are five key components of the framework: 1) Make health equity a strategic priority; 2) Develop structure and processes to support health equity work; 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact, such as health care services, socioeconomic status, physical environment, and healthy behaviors; 4) Decrease institutional racism within the organization; and, 5) Develop partnerships with community organizations to improve health and equity. At the Blue Retreat (5th in the in-person training series), faculty discuss the business and moral case for applying an equity lens to organizational policy in healthcare. In the two-hour session, Fellows are asked to think about the leadership skills they have acquired and how they might apply the IHI framework to their work or advocate for its application in their organizations. In small groups, Fellows brainstorm each component of the framework and use a gallery walk methodology to share out and discuss examples.

5. Challenges and lessons learned

The development of a new training program and curriculum comes with its challenges and lessons learned. There are four areas of our work in the Clinical Scholars curriculum that challenged the program staff to think in new ways about leadership development.

5.1 Challenge #1: the personalized nature of the journey of self-development

The CS team built the curriculum very thoughtfully and intentionally, from information collected from the literature, institutions of higher learning, organizations widely respected for their equity work, and team and partners' expertise and knowledge. We anticipate and are confident that this curriculum will spur improved and successful behaviors and approaches by Fellows within their clinic settings and community-based work. At the same time, we recognize the personal nature of one's growth-journey in EDI is brought about by one's own identities, background, and readiness to advance their EDI proficiency. While we select for participants and teams that center equity as an approach to their Wicked Problem Impact Project, we have found the continuum of values and beliefs, behaviors and practices is not narrow. We have seen the unevenness of how a session's learning can land for a

cohort of Fellows. For some, content is new and can feel paralyzing, while for others the content might feel familiar, and even too rudimentary. Additionally, we have learned that Fellows can fall prey to assumptions about how their own beliefs are directly reflected in learning sessions, and how both challenging and enlightening it can be to gain insight into where one stands on the EDI growth-journey in a relative sense. The program is called to support all Fellows by helping those earlier in the growth-journey to feel brave enough to continue the work, and those who are further in the journey to show both grace to others and humility to see this journey has no end, as there is always more to understand, know and do.

The ways we support all Fellows are through intentional program structure and design. Building strong relationships between the participants from the start helps them to challenge one another and foster their individual and collective growth. Another tool we use is safe and open cohort-based discussions about EDI session content; these discussions often provide insights to previously uninvestigated assumptions and attitudes that allow everyone to move to a new place in their EDI learning journey. Most importantly, we work to react well to the variety of responses to content by providing sufficient supports for individuals no matter where they are on the growth-journey. The characteristics of the Fellows described earlier mirror the characteristics of the CS staff team; the EDI growth-journey is something all invested in this program are participating in. To better shore up the sensitivity with which we respond, the CS staff team is encouraged and has dedicated funding to further develop their own EDI skills and awareness through workshops, training, and conferences.

This challenge we are describing is further exacerbated as the program strives to include lessons from all 25 competencies within the in-person and distance-based sessions and activities. This leads to a packed schedule, which might not meet the learning styles of all participants. While clinicians are familiar with this type of intensity in professional trainings, the nature of EDI topics elicits more emotional response and calls on more mental and emotional energies than traditional leadership topics. As CS staff saw this play out in both the EDI and leadership in-person sessions, the curriculum and schedule were modified to have dedicated reflection and preparation times and tools to support the Fellows for the unique work needed for EDI area advancement. Providing more space and time to process content, and balancing the delivery of new content and the time allotted for digestion of that information, have been two essential approaches for effective EDI competency training. In addition, Fellows are provided with more than a dozen books addressing EDI and leadership topics over the three years and weekly "self-reflection prompts" are sent via email to all Fellows, providing structure and guidance for continuing this growth-journey in between the onsite retreat sessions.

We acknowledge that leadership growth is a personalized intellectual and emotional journey that needs immediate and ongoing attention. Related formally scheduled sessions focus on stress management and managing difficult conversations. The program team incorporates breaks for reflection and self care and pairs Fellows with peers in other cohorts for peer support. Executive and team coaches are present during onsite meetings to offer additional support. Fellows have access to an open space to practice yoga or Zumba and often assemble for group outdoor walks and runs. The structured and iterative nature of the program allows the CS team and Fellows to learn from Fellow's experiences and reflections. For example, an optional Structural Inequalities training offered by our partners, Community-Campus Partnerships for Health, included an expedited and condensed photovoice activity in which participants presented self-captured and selected photographic images representing inequality in their communities and shared the structural context of the photo. Fellows and other participants via consensus selected a photo

reflecting injustice and engaged in guided discussion about the underlying factors using the SHOWED method [36] meant to engage groups in critical dialog about vital shared community issues. Hours after the training, one of the guest youth participants was detained from entering the event's hotel by security. Learning of this incident, participants discussed their roles and action steps as actors, allies, and accomplices in social justice, recognizing that the systems that they work and live in are not set up to readily support these EDI concepts.

5.2 Challenge #2: shifting mindsets and skill sets

Teaching negotiation tactics--a traditional leadership development topic--is about strategy and skill. Teaching how to meaningfully engage in authentic partnerships with communities--an EDI competency--is about strategy, skill, and *shifting mindsets*. The case for "why we need leadership" is ingrained in the American way. It is underneath so many of the lessons in our school systems, and is embedded in the language of organizations. The case for "why we need equity, diversity, and inclusion" has not permeated the language and minds of school, organizations, and communities in the same way. While many organizations in the last several years have begun to understand and make the business case for EDI, it is not a universally accepted core principle. The need to act in ways that are fair, just, and equitable to all people despite their differences is not ingrained in people, in the organizations they participate in, or in the systems in which they live. This adds to the burden and the importance of the EDI core. Participants will not take in or hone skills around EDI if they do not first have the shift in mindset needed to appreciate difference, celebrate it, and leverage it so they can see why those skills are important in the first place.

Furthermore, there is a push and pull of issues that need attention in healthcare. Racism is the most critical--it bookends the other oppressed identities in our nation's historic past--but it is not the only source of oppression. Sexism, ableism, classism, elitism, ageism, and others are also present in our systems and unfairly advantage some while disadvantaging others [26]. Each person is coming in with their own experience and identity, and in their own place in the journey. And, the journey is multi-dimensional in multiple ways. First, for the most part, Fellows come into the program understanding some areas of disadvantage, but not all. If a Fellow comes into the program with a very deep understanding of structural racism, but has not learned about disability issues, the work of the program is to assess where they are in the journey and what axis they are on in terms of thinking about oppression. The role of the program is to then create the space and elevate the need to broaden the lens each Fellow brings. Additionally, each Fellow themselves holds multiple identities, some of which might offer them privilege and others which disadvantage them. The intersectionality of identities presents further need to expand program learning to discuss the ways in which each "ism" works individually and is interconnected in the system. And finally, there will be times in their leadership work that a Fellow may not hold a particular identity that is being oppressed (e.g. Black, female), but because of that they have an obligation to advocate for others in those oppressed groups because of the advantaged position they hold. So we teach allyship as an important social lever we can pull to ensure the equity and diversity we are talking about.

Over and above that, the program meets these challenges by offering a variety of opportunities and examples over time and across competency sets to explore these issues in a safe and welcoming environment. We endeavor to put many illustrations of the complexities of inequality and difference in front of the Fellows, both as individuals, in their project teams, and across the entire group. Some examples of this follow. As mentioned, the program offers a Special Experience which focuses on structural racism and historical trauma. In our seven consecutive training intensives,

sessions endeavor to weave the intersectionality of multiple issues throughout. The poverty simulation, described above, contrasts Fellow's daily experience with those living under both the conditions of poverty and the prejudice against it. In our Blue retreat (5th in the program series), a session specifically addresses the competition between diversity issues and how that can be destructive to anti-isms work and health equity coupled with skill building for being an ally. Additionally, sessions in the leadership core are based on the concept of "thought diversity" with several focused specifically on the differences in personality types that lead to differences in behaviors. The wide range of ways the program highlights differences (in personality, in social identity and culture, in experience) helps Fellows create organizational and team cultures that embrace differences more clearly, positively and openly.

Finally, we speak and model at every turn in the curriculum the grace we need in order to understand each other and support each other in the journey of reaching equity, diversity and inclusion in our lives, our workplaces, and our communities.

5.3 Challenge #3: piloting an evidence-based curriculum on EDI

It has been a challenge to find an evidence-based curriculum that embraces the breadth of leadership, equity, diversity and inclusion mandated by the charge of the RWJF funding. Piloting a newly designed, never vetted, 3-year EDI curriculum has held its share of challenges. While CS staff and partners brought a wealth of session topic examples and speaker ideas for the leadership core, the same level of tested topics and speakers was simply not available for the EDI core. Following the development of the Behavioral Impact Goals and Curriculum Map (see more information on both above), the team spent an incredible amount of time, energy and resources looking into already existing curriculum on EDI topics, and through the personal networks of staff and partners, for the bits and pieces that would fit within our EDI Leadership ideals. Sources for components of our curriculum that are widely available include trainings available from VISIONS, inc, a non-profit training and consulting agency specializing in diversity and inclusion (https://www.visions-inc.org/) and the *Transforming White Privilege* curriculum, a joint project of The Center for Assessment and Policy Development (CAPD), MP Associates, and World Trust Educational Services, funded by The W.K. Kellogg Foundation (https://www.racialequitytools.org/module/overview/transforming-white-privilege).

Furthermore, the topics of racism, sexism, classism, intersectionality, privilege and oppression can be quite charged. Any given session in our curriculum has a limited time frame, in an effort to meet the requirements of the program funders and the overall program goals. We cannot address everything that could be addressed, leaving some topics to be addressed in more superficial ways than would otherwise be needed to truly dig deeper into any given form of oppression/privilege dichotomy. A third struggle in piloting this curriculum has been around evaluating its effectiveness. Identifying the evaluation concepts overall to measure the desired competencies, and identifying measures of speaker success and content appropriateness has been challenging.

We have also experienced the challenge of making and implementing a curriculum with longevity in the face of an evolving societal awareness and response to new thinking around EDI concepts and terms. In order to avoid stagnation and teaching dated viewpoints, the Clinical Scholars team continually scans the larger landscape of key EDI discussions and research for important updates to the curriculum. The curriculum itself is designed with embedded flexibility for such updates, while maintaining proven methods and formats. Outside of the set curriculum, we offer other learning opportunities where unfolding information and new resources can be shared, such as weekly journal prompts and popular and scholarly articles and books.

5.4 Challenge #4: maintaining engagement with participants over time and across distance

The inclusive national nature of CS involves healthcare professionals distanced by geography (to date-25 states, Washington, DC, and Puerto Rico), discipline, and focus area, which creates challenges to engagement and building a sense of community. A hybrid in-person and distance-based leadership program can be challenging for all learners but especially so for providers who maintain full time employment and busy households. What unites these diverse Fellows is a common sense of purpose and commitment to make a positive impact on health well-being within their communities.

Research conducted of online learning demonstrates that learning effectiveness is optimized by learning formats in which learners interact with both instructors and classmates and actively participate in activities [37–39]. The CS program team strives for continuity, engagement, and responsiveness to leadership development in the context of real-life. While participants only convene in person three times a year (biannual CS intensives plus an RWJF-sponsored Annual Leadership Institute), contact is maintained with each Fellow cohort weekly with updates on program components and news about peers. News of Fellow accolades, promotions, professional and personal accomplishments are publicly acknowledged in the weekly updates to build comradery. Fellows are oriented to the online learning management system to communicate with staff, coaches, and each other, view the distance and in-person schedules, make travel arrangements, and access/submit program requirements.

Adaptations to the curriculum are responsive to Fellow real-life demands and feedback that some requests were duplicative and not harmonized. Fellow onboarding evolved into an integrated process coordinated between the CS Deputy Directors. The integration was needed to streamline contact with and requests from RWJF and their affiliates, communicate required and optional components of the program, prepare Fellows for their first in-person session and online session, introduce the online learning environment, and properly acknowledge and introduce Fellows on our website. Online monthly webinars were reduced from three a month to one every four to six weeks. Similarly, team coaches created a team coaching guide to anticipate the needs and potential experiences of teams throughout the three years of the program. Fellows received annual requirements framed as asynchronous learning to be completed annually, with suggestions to complete them on a regular basis over 2–3 hours per week. Fellows received individual quarterly progress reports of their completion of requirements.

External to program components, the Clinical Scholars team connects Fellows with mutual interests, approaches, challenges, and disciplines. Fellows organically make similar connections during onsite sessions and Fellows also facilitate connections within the Clinical Scholars program and across their networks serving as assigned or automatic peer mentors during and following the program.

5.5 Top recommendations for weaving EDI and leadership learning

- Support Fellows in developing detailed Group Agreements (See **Table 2**). These kinds of agreements can create the container that will hold the group's trust and fears, can be used to frame difficult conversations and learning across the program, and can be referred to when group norms are violated by staff, speakers, or participants.

- Ensure all persons connected to the program (leads, staff, speakers, coaches) also hold the important EDI values being fostered in this program.

Example Group Agreements		
• Be a humble learner • We have/are responsible for "stuff", conscious and unconscious (bias, "accessories", etc.) • Assume best intent & respect impact • Take risk to be vulnerable • Practice self focus (I believe, I feel) • It's OK to be YOU (be authentic) in this space, in your growing edge. (see other guidelines) • Allow growth for self and others • Listen with intensity usually reserved for speaking	• Move in/Move out of the interaction (neither dominate nor abdicate) • Be present in the room • Be gracious, not grumpy • Have one another's backs • Stay focused on 'big idea' • Allow quieter voices to be heard • Non-judgmental/curiosity • Welcome and seek out thought diversity • Practice patience... • Compassionate feedback • Extend grace to others	• Words matter • Practice "both/and" thinking • Try things on • Have fun! • Experience joy! • Keep confidences • **And,** *confidentiality* **means:** • Take away themes and A-HAs • No attribution to others • No sharing other's stories • No telling stories about others • Also, be vulnerable, but share comfortably
These agreements were created by the fellows themselves (developed by Cohort 4 in fall 2019) over the course of multiple, iterative discussions in the first onsite experience of the program, and are brought back to each experience moving forward.		

Table 2.
CS cohort 4 group agreement.

- Create a protocol for staff to follow that offers a road map if, within a session or event, a Fellow is triggered, then staff move to offer any needed support to that participant.

- Create a protocol for staff to follow if a speaker's content or examples used within a session rub against the very EDI mindset you are working to achieve (e.g. use of microaggressions).

- Be prepared to stop other content-based programming to support the emotional and mental health needs of participants.

- The program will have missteps. Be humble enough to acknowledge, and agile enough to find a more effective path.

- Fellows will misstep. Create a trusted, safe, and brave space from the beginning to both hold missteps to account, and to extend the grace needed for continued self-focus and learning in the process.

6. Conclusions

Leadership development programs can be found in every industry and every field. A 2012 report showed that US companies spend $14 billion annually in this area [40]. These programs are often exclusive to traditional concepts of leaders focusing on conflict management, negotiation, and communication skill sets. The Robert Wood Johnson Foundation intentionally funded Clinical Scholars to expand the traditional

model of leadership development to include equipping health care professionals with tools around equity, diversity and inclusion so that they could meaningfully impact the social determinants of health in their own communities. The Clinical Scholars National Leadership Institute team has found that the blending of leadership and EDI work is crucial to preparing leaders to face the health equity problems of today.

One participant wrote:

Not only have I grown as a leader, but also in terms of self-confidence and awareness that I can make change happen. I have found my voice, in advocating for change. I have found lasting friendships and partnerships, with individuals that have a shared sense of purpose. Through my individual growth, as well as growth within my team, we have made a change in the lives of those we serve, and within our communities. – Asha Davis, MD.

Appendix A: clinical scholars competencies and definitions

Personal Level Competencies
***Commitment to Intercultural Development**: continually increase one's awareness, content knowledge, cognitive sophistication, and empathetic understanding of the complex ways individuals interact within systems and institutions; develop and demonstrate an active, intentional, and ongoing engagement with diversity: in people, in the team, in populations, and in communities, with respect to ability, intellectual, social, cultural, geographical [41].
Emotional Intelligence: Ability to assess and understand the emotions of one's self, others and groups; the ability to relate to others beyond technical concerns; the ability to implement soft skills in interpersonal or organizational settings and manage stress [42, 43].
Self-Awareness: Assessing and understanding your personal leadership strengths and development areas (weaknesses); being aware of how personal preferences and leadership style differ from others; understanding what you still need to learn; the ability to "own" mistakes; use self-examination and reflection to create a life-long leadership learning plan [44].
***Social Justice:** Develop the knowledge, skills, and disposition needed to create environments that foster equitable participation and self-determination of all groups while seeking to address and acknowledge issues of oppression, privilege, and power [45].
Inter-Personal Level Competencies
Communication: Effectively communicate with individuals and groups representing diverse stakeholders both within and without the organization; speak in a clear and concise manner in both routine and high tension situations, with individuals, groups, and the press.
Conflict Management: Use dialog to solve critical problems; implement alternative dispute resolution strategies; successfully manage conflict between people or groups.
Innovation Orientation: Implement interpersonal strategies to promote the generation of new ideas, approaches, and processes; engage in innovation and entrepreneurship at a personal level in addressing wicked problems that impede achieving a culture of health.
Negotiation: Engage in productive dialog to resolve disputes between either people or organizations; represent/defend the interests of your organization/self when crafting agreements with other parties while creating new opportunities for partnerships and collaboration.
***Practice of Multi-Culturalism:** articulate and readily integrate into their work the concepts of identity, culture, equity, diversity and inclusion; examine and build respect and appreciation for individual differences (e.g., personality, learning styles, and life experiences) and group/social differences (e.g., race/ethnicity, class, gender, sexual orientation, country of origin, and ability as well as cultural, political, religious, or other affiliations) that can be engaged in the service of learning and working together [46].
Visioning: Create a compelling, engaging vision that embraces a holistic perspective of a chosen concept; integrate the vision with the mission of the larger organization; inspire others to work towards achieving that vision as well [47].

Organizational Level Competencies
***Organizational Capacity for Advancing Health Equity**: Understand and develop techniques, approaches and strategies to advocate for transformation of systemic power structures and policies such that shared power arrangements, increased community access and engagement, and equitable outcomes result [48].
Organizational Culture: Create an organizational culture that embraces varying skills and perspectives to capitalize on the contributions of various members; impact the organizational culture of groups such that members are engaged and mission-focused; create a work environment where group member satisfaction is high and people feel valued, engaged, and utilized to their full potential
***Diversity and Inclusion:** Foster cultures that support diversity and inclusion; employ language and behaviors that acknowledge that a community or institution's success is dependent on how well it values, engages and includes the rich diversity of its members or constituents [49, 50].
Implementation Science/Evidence-based practice: Identify and utilize factors and methods to examine the process of implementation to effectively operationalize proven interventions and produce positive outcomes [48].
Performance Management for Innovation: Develop measures of performance improvements; develop and/or implement performance standards which foster accountability and facilitate innovation; link performance measures and standards to a potential strategic plan/innovation plan for the organization; implement systems to promote innovation at the team or organizational level
Change Leadership/Change Management: Understand personal change style and personal preferences when navigating change; identify the need for organizational change; understand the cycle of organizational change; implement processes to bring necessary changes and achieve organizational sustainability [44].
Systems Thinking: Identify systems influences of wicked problems in planning solutions; implement systems theories to address organizational change and transformation; build organizational capacity to envision and select system-wide strategies to address acute problems.
Political Thinking: Developing and implementing political strategies both within the organization and externally.
Community & Systems Level Competencies
Advocacy: Influence groups, policy, public policy, and resource allocation decisions within political, economic and social systems and institutions; create persuasive dialog to support one's issue or goal.
Collaboration and Partnerships: Recognize and reconcile emotional and rational elements in collaboration-building and strategic planning; create opportunities for individual, team, and organizational success through the development of creative partnerships internal to and external to the organization; link partnership development with community impact, positive revenue streams and sustainability.
Futuring: Assess current trends for potential future developments in programs, concerns, political agendas, or concepts that are aimed at building a culture of health; contribute to creating the relevant systems of the future through technology, innovation, partnerships, and political influence.
***Health Equity**: Pursue the highest possible standard of health for all people, with special attention to the needs of those at greatest risk of poor health, based on social conditions; champion and advocate for interventions or policies that advance the opportunity for all to attain their highest level of health [48, 51].
***Meaningful Community Engagement:** Employ the four specific elements of authentic community engagement - 1) Guiding Principles of Partnership, 2) Quality Processes, 3) Meaningful Outcomes and 4) Transformative Experience(s) while working collaboratively with and through groups to address issues affecting the well-being of those people to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes [48, 52].
***Social Determinants of Health:** Understand how the social determinants of health impact both individuals and communities; integrate intervention strategies and policies to address social determinants of health into approaches of the Wicked Problem Impact Project [53].
Stakeholder Analysis: Assess and analyze important players/factors that contribute to or impede individual, team, or organizational success; develop and implement strategies to align stakeholders to organizational mission and vision [54].
**Designate EDI focused competencies.*

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