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Introduction

The pandemic and protests of 2020 heightened public awareness of systemic disparities and racial inequities across the United States (Chowkwanyun & Reed, 2020). With this greater awareness and growing calls for change, many foundations expressed commitments to fostering equity and supporting systems reforms in a range of sectors and spaces (Kresge Foundation, n.d.; Neyman, 2020; Coke & Naylor, 2020; Walker, 2020; Torres-Springer, 2020; David & Lucile Packard Foundation, 2021; William & Flora Hewlett Foundation, 2020; Ono & Fong, 2020; DeBarger, 2020; Gates, 2020a, 2020b; Proctor, 2021). We believe, as do others, that a key to advancing and sustaining equity is supporting and cultivating new leaders among diverse individuals and communities often overlooked in traditional leadership programming (Sharma, 2017; Davies, 2018). Foundations are in a unique position to invest in and build upon inclusive leadership programs, which we define as programs that aim to expand the pool of emerging and effective leaders from all walks of life. This broader, more diverse pool of leaders can then fuel wider changes to systems, increase access to opportunities for historically marginalized populations, and yield more equitable outcomes (Stephan, Vahdat, Walkinshaw, & Walsh, 2014; Davis, 2018; Lyons, 2019; Khan, 2014).

As foundations continue to invest in efforts designed to reduce systemic disparities and racial inequities, and work to understand their

Key Points

- Over the course of 12 years, the Blue Shield of California Foundation committed nearly $20 million to growing a pool of community health center leaders who were prepared to be effective agents of change in their organizations and in the safety net field. This signature investment, the Clinic Leadership Institute, was implemented in partnership with the Healthforce Center at University of California, San Francisco, in anticipation of a generation of California health center leaders beginning to transition into retirement.
- During the institute's 10 cohorts, access to community health centers dramatically increased with the Affordable Care Act, and this — coupled with rising costs of health care — continued to underscore how crucial community health centers were to accessible and quality care for poor and underserved populations. A study spanning 10 cohorts of alumni found that the institute served a critical role in supporting community health center leaders and their organizations in navigating these changes, while also building alumni networks advocating for community health centers in county- and state-level policy. The program equipped 258 individuals to lead and deliver care in a field marked by continuous change, complexity, and mounting demand.

(continued on next page)

Key Points (continued)

- Drawing on these findings, we make the case that investment in leadership development is a critical philanthropic tool for field building and, ultimately, systems change. We explore how the foundation made the most of this investment through intentional funding, design, and strategic considerations.

benefits, we want to highlight our experience with the Clinic Leadership Institute (CLI), a program for emerging community health center (CHC) leaders. Over 12 years, the Blue Shield of California Foundation (BSCF), in partnership with Healthforce Center at University of California, San Francisco, implemented the CLI to grow a pool of leaders in California who could collectively and individually act as effective agents of change in the safety net field — defined by the Institute of Medicine (2000) as care and service providers supporting uninsured, Medicaid-receiving, and vulnerable populations. In what follows, we describe the impetus and structure of the program, share key findings, and identify five key lessons learned in sustaining the program:

1. Investing in new leaders is a long-term commitment.
2. Effective partnerships share power.
3. Diversity and inclusion require ongoing monitoring.
4. Sustain collaboration beyond the program.
5. Measuring impact requires sustained investment.

Inclusive Leadership in Community Health Centers

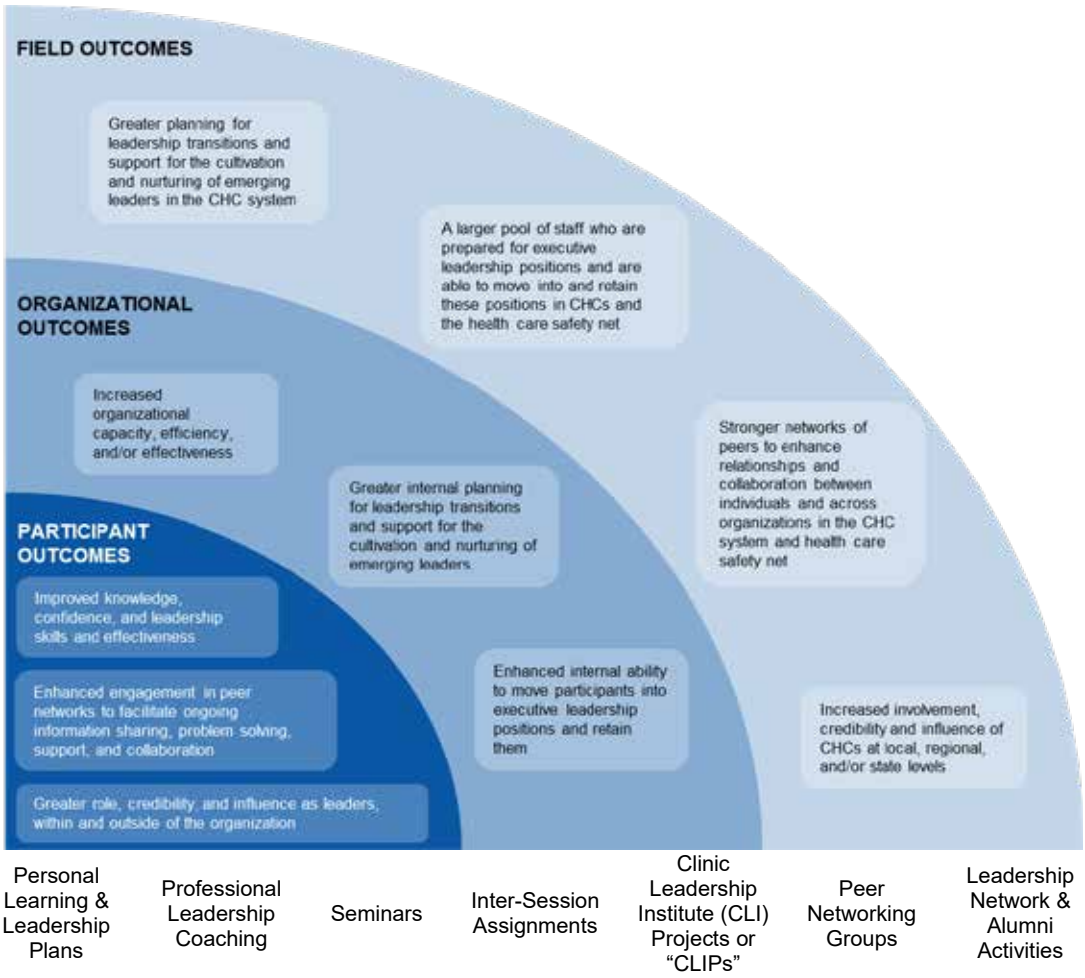
Established in the 1960s, CHCs were founded on the belief that everyone, regardless of socioeconomic status, deserves access to affordable community- and patient-driven health care. Health centers play a vital role in meeting the needs of patients underserved through private health care providers and are a central feature of the safety net. Health centers not only provide care, but also extend access to care by providing enabling supports such as transportation and translation (Health Outreach Partners, 2016; National Association of Community Health Centers, 2020a).

Health centers also play a key economic role in making government-subsidized care possible. Compared to other providers, health centers save 24% per patient annually. These savings make reimbursement scalable for government health insurance programs such as Medicaid and Medicare. Accordingly, the role of CHCs grew to even greater prominence with the passage of the Affordable Care Act in 2010. With the expansion of access to Medicaid they saw a sharp increase in use; the number of patients served grew by more than 50% between 2010 and 2016 (National Association of Community Health Centers, 2018).

Community health centers, therefore, have a powerful role to play in improving health care for all, and they need leaders with the skills, networks, and lived experiences that support them in working alongside communities — particularly those historically underserved. Leaders of CHCs must lead with the social justice and community values that support effective access, care, and engagement. At the same time, they must embrace the challenges and opportunities of a rapidly changing health care field, rising demand for CHC services, an uncertain health care policy landscape, and deepening health inequities (Bor, Cohen, & Galea, 2017).

The need for an expanded leadership pool was further highlighted in the early 2000s, in studies that predicted that tenured nonprofit leaders, including those in the CHC sector, were preparing to transition out of their roles and that a gap in the leadership pipeline was approaching. They reported that a limited number of "next generation leaders" were ready and eager to accept senior leadership positions (Cornelius, Moyers, & Bell, 2011; Cornelius, Corvington,

FIGURE 1 The Clinic Leadership Institute's Theory of Change



& Ruesga, 2008). The demand for these leaders in rural and high-poverty areas, which face challenges recruiting new talent, is even greater (Chang, Bynum, & Lurie, 2018; National Association of Community Health Centers, 2020b).

The Clinic Leadership Institute

Recognizing the urgent need to prepare a new generation to lead California's CHCs, the BSCF in 2008 committed to investing $20 million over 12 years to expand the pool of emerging health center leaders across the state. The foundation built the program on a historical commitment to building and sustaining a field that is responsive to communities and the evolving health care field. The central focus of the investment was not just to produce individual, capable leaders, but also to do so in service of the CHC field's stability and longevity.

The Healthforce Center, which focuses on building the capacity of the health workforce through pioneering leadership programs; an advisory committee of CHC executives; and the BSCF together designed the CLI as an 18-month statewide program for full-time CHC employees to prepare individuals for executive positions in

FIGURE 2 The Clinic Leadership Institute's Curriculum

CHCs. The primary participants were a CHC and consortia staff who demonstrated executive leadership potential and a commitment to preserving and enhancing CHCs and the broader safety net.

The goal of the CLI, as articulated in its theory of change, was to expand the pool of committed, knowledgeable, and collaborative CHC leaders dispersed throughout California to advance the influence of the centers on policy and care delivery. This was seen as central to the stability of the CHC and safety net fields in a shifting health care landscape. The seven core components of the CLI model — from personal learning and leadership plans to leadership network and alumni activities — were theorized to collectively support changes at the participant, organization, and field levels. (See Figure 1.) Those outcomes are nested and interdependent: changes for participants, for example, have ripple effects on changes at the field level.

The program sought to build participants' skills, roles, confidence, peer support, and professional networks as a means of strengthening their organizations and their impact on the field. (See Figure 2.) To bring this about, the 18-month program included the following core components and alumni activities:

- Personal learning and leadership plans: After completing personal assessments and receiving input from colleagues and staff, participants created individualized leadership development plans to guide them through the CLI experience.

- Seminars: Six in-person seminars, totaling 220 hours over the course of the program, bolstered participants' knowledge and skills through instruction, field-specific topics and scenarios, group problem solving, and role playing.

- Inter-session assignments: Approximately three hours of inter-session work was assigned per week, including readings, webinars, group activities, and apply/practice work.

- CLI Projects or "CLIPs": Participants implemented customized leadership projects at their health centers that allowed them to practice their skills (e.g., securing buy-in, managing people and processes, measuring

progress) while also working on an organizational need.

- Professional leadership coaching: Each participant had access to nine hours of one-on-one coaching — personal, customized, and confidential support — during the CLI, plus six hours after graduation.

- Peer networking groups: Groups of approximately five participants met throughout the CLI to facilitate more intimate peer connections, learning, and support.

- Leadership network and alumni activities: Participants had structured opportunities during and after the CLI to connect with and learn from fellow alumni and colleagues from other health centers.

Between 2008 and 2018, the program graduated 258 alumni from 10 cohorts. Annual evaluations of the first five cohorts, a midpoint assessment completed in 2015, and a 2019 cumulative 10-cohort evaluation surfaced important benefits of the CLI model. These mixed methods evaluations included surveys and interviews with program participants and alumni; surveys and interviews with CEOs and colleagues of health centers that sponsored participants; observations, materials, and secondary data review; and interviews with the CLI design and implementation team (Informing Change, 2015, 2019). In keeping with the theory of change, CLI participants and alumni reported substantial gains in personal and professional growth, drew on the program to make changes within their organizations and the field, and described it as important to their career trajectories in CHCs and the broader health care safety net.

Personal and Professional Growth

Participants and alumni consistently demonstrated growth in self-awareness and their knowledge and understanding about leadership in the CHC field. (Figure 2). Notably, participants described CLI as influential to their:

In keeping with the theory of change, CLI participants and alumni reported substantial gains in personal and professional growth, drew on the program to make changes within their organizations and the field, and described it as important to their career trajectories in CHCs and the broader health care safety net.

- confidence as leaders (94%) — reporting greater comfort speaking up, sharing opinions, and standing by their decisions;

- knowledge about leadership in the health center field (93%) — reporting greater awareness of the nuances of health center operations and business, as well as the implications of policy changes and dynamics on the field; and

- leadership skills and effectiveness (92%) — reporting greater skills in communicating, decision-making, delegating, listening, visioning, and presenting ideas, particularly when addressing strategy and other high-level organizational issues.

"Even though I was told I was a leader," one participant remarked, "I don't know [if] I'd have claimed it. CLI really helped me realize and see the power of owning my role as a leader."

Career Trajectory and Advancement

Despite promising contributions of the program to participants' career trajectories and engagement with the field, the evidence of impact was less pronounced than on personal and professional growth. Across cohorts, nearly 90% of participants reported that the CLI had deepened

Investing in community health center leadership was a core priority for the BSCF; it served as one of a trio of field-building strategies that also included technical assistance and core operating funding to safety net organizations.

their professional commitment; as of 2018, 89% continued to work in the safety net field. Although many stated that the program was influential in building their confidence to advocate for promotions and negotiate raises, the evidence of movement into executive positions was mixed — in part due to the effect of the 2008 recession on C-suite vacancies.

Nevertheless, most (71%) alumni reported advancing to more senior roles and benefiting personally and professionally from the connections with and community of other CLI alumni. The program, said one, "gave me the ability to move with confidence into a temporary CEO role. It gave me the courage to believe that I could excel in the position, and I did."

Organizational and Field-Level Change

Participants reported the benefits of the CLI on their spheres of influence within CHCs and the field at large: 88% said their influence as a leader has grown, and 73% reported engaging the alumni network to generate new ideas and approaches. Combined with expanded technical skills acquired through the program, these leaders were able to help their CHCs better address a range of challenges, such as streamlining operations, improving patient engagement and experience, and tackling workforce shortages and training. Participants reported taking on new responsibilities to enhance organizational performance, for example:

- opening a satellite office,
- overseeing program quality,
- implementing electronic health records,
- leading patient-centered medical home efforts and other novel practices, and
- representing the organization at field-level conferences.

The CLI created a community of leaders and advocates who are beginning to bring policy solutions to statewide conversations on health care. Connections made through the program led to deepened collaboration among individuals and across CHC organizations and the health care safety net. Alumni are actively engaged in collaborations and groups that work to improve the field through policy responses (e.g., addressing workforce shortages, access to electronic health records, expansion of telehealth), generating ideas and innovative approaches, and fostering a sense of belonging across community clinics in California. These venues for collaboration include the Rural Roundtable, the California Primary Care Association, and the Health Education Roundtable.

"In order for our health centers to be sustainable," one participant said, "we have to evolve. We have to expand our networks. We have to know how to engage in successful collaborations with others."

Investing in Inclusive Leadership: Five Key Lessons

The findings from the CLI evaluations bolster the program's theory of change — that developing emerging leaders is an important tool for shaping and sustaining CHCs. Our experiences funding, implementing, supporting, and evaluating the program produced a number of insights that can be of use to other foundations investing in field-building, inclusive leadership programs.

Investing in New Leaders Is a Long-Term Commitment

Investing in community health center leadership was a core priority for the BSCF; it served as one of a trio of field-building strategies that also included technical assistance and core operating funding to safety net organizations. Initially, the foundation made an investment of $10 million over five years. Based on early successes and learnings, as well as a desire to expand the pool of emerging leaders and the benefits across the field, it soon increased this investment by an additional seven years, adding another $10 million. We recognize that these costs may be prohibitive for some foundations, and recommend that grantmakers look at different models of funding these deep-engagement, cohort-model inclusive leadership programs — for example, by pooling funding with other foundations to provide low-cost or no-cost enrollment for participants or their sponsoring organizations.

The BSCF's 12-year commitment to 10 cohorts meant a critical mass of emerging leaders — over 250 individuals — could participate in the program. The depth of funding was essential to implementing a multifaceted program for capacity building, where participants could tailor portions of their experience. This allowed participants to draw on the types of resources most relevant to their role, professional growth, and their organization's needs.

The BSCF's commitment, however, extended beyond just funding. Foundation staff were partners with Healthforce in program implementation, actively engaging in its evolution and informing recommendations to strengthen the program. The consistent support from the foundation meant that program staff could invest in designing, adapting, and witnessing results of the model over 10 iterations.

The sustained investment was also key to supporting a community of leaders that could collaborate on policy and systems change. For example, CLI alumni were at the forefront of the 2017 debate on payment reform in California. While the time frame for health policy change extended far beyond the scope of the cumulative evaluation, CLI alumni networks have joined in advocating for policy solutions to workforce shortages, expansion of telehealth, and health equity. From the perspective of one alumnus, "CLI alumni are part of field-level conversations on responding to policy changes. Some of the ideas that have come out of them are coming from this new emerging leadership."

By stepping back, ceding power to, and actively engaging those in the field, and taking an active role as a thought partner, facilitator, and collaborator, the foundation was able to realize its commitments to investing in people in ways that expand leadership capacity, equity, and responsiveness in the field.

Effective Partnerships Share Power

Sustaining an effective, multicohort leadership program was possible through close relationships and by establishing opportunities to engage and learn from participants. The strength of CLI was fostered through the partnerships embedded in the program design and that evolved during the program. The BSCF established an intentionally inclusive approach to partnership, grounded in mutual learning, with Healthforce and the program's advisory committee. By stepping back, ceding power to, and actively engaging those in the field, and taking an active role as a thought partner, facilitator, and collaborator, the foundation was able to realize its commitments to investing in people in ways that expand leadership capacity, equity, and responsiveness in the field.

TABLE 1 Demographics of CLI Participants at Time of Entry Into Program

Participants		
California Region	**Number**	**%**
North Coast	22	8%
Far North	16	6%
Bay Area	90	32%
Central Coast	14	5%
Central Valley	35	13%
Los Angeles	53	19%
Riverside & San Bernardino	5	2%
Southern California (San Diego & Orange County)	36	13%
Statewide	7	3%
Gender		
Female	226	81%
Male	53	19%
Ethnicity/Race*		
White	100	36%
Asian	30	11%
Latino/Hispanic	103	37%
Native Hawaiian or Pacific Islander	3	1%
African American	20	7%
American Indian Or Alaskan Native	12	4%
Other	18	6%
TOTAL	**279**	

*Ethnicity/race category redefined in 2010. Asian and Pacific Islander groups combined.

Partnerships were essential to successful recruitment and to ensuring the program design met the needs of emerging leaders. Advisory committee members — CHC executives from across the state — brought credibility to and raised awareness about the CLI among health care centers. At the same time, the advisory group and Healthforce raised the BSCF's understanding of the CHC field. Healthforce brought expertise in leadership development, the safety net field, and workforce challenges. Healthforce staff held responsibility for program design and implementation, and ensured the program's strategic alignment with the evolution of CHC services, financing, operations, workforce, and policy advocacy. Engaging Healthforce and the advisory committee as mutual partners helped the foundation ensure the program's responsiveness to rapid expansion of CHCs and the changing safety net field.

Diversity and Inclusion Require Ongoing Monitoring

A central goal of CLI was establishing cohorts of emerging leaders who reflect the diversity of safety net providers and communities in California. Realizing this goal required continuous reassessment of successes and gaps in outreach, reimagining new approaches to recruitment and selection, and critical reflection on structural impediments and interpersonal biases that challenge inclusion and diversity intentions. The program's evolving outreach saw both wins and challenges.

Initial outreach was done through the advisory committee of clinic executives. Program staff also worked with regional consortia, county-specific or multicity-specific associations that serve as informal extensions of state CHC associations, to identify ideal program candidates. Consortiums' reach and networks made them important partners in identifying emerging leaders. As the program's alumni and reputation grew, recruitment was conducted through participant and alumni referrals, e-newsletters, and social media (i.e., LinkedIn, Facebook, Twitter).

Review of demographic and geographic representation in the early and midpoint cohorts raised awareness that the program was not attaining a diversity of participants. To correct for the underrepresentation of specific demographics — particularly Black, Indigenous, and rural representation — CLI implementers focused recruitment efforts using strategies such as individual outreach to specific organizations with few or no CLI applicants or participants. Program staff also researched demographics that were underrepresented in the field's top leadership, and demographic goals based on ethnicity, gender, geography, and type of position (e.g., finance, information technology) were identified. The program then focused on outreach to CHC leadership in underrepresented regions, including Los Angeles, the Central Valley, and the Inland Empire of California. While these efforts resulted in racial/ethnic representation that mirrored California's population, overrepresentation of urban geographies persisted. (See Table 1.) Some of this is attributable to such barriers such as travel from rural regions to attend in-person trainings and the inability of rural organizations to backfill positions to support staff's participation in the CLI.

As disparities in program representation became evident, the CLI team took steps to correct for this where possible. For example, early in the program design, the BSCF and Healthforce defined what they meant by "emerging leader" and then developed proxy indicators to use as selection criteria. Program staff determined common behaviors and characteristics associated with successful participants, but some of these criteria reinforced existing gaps. For example, early criteria looked at the number of years an "emerging leader" had been working in CHCs, and at restricting enrollment to a single participant from an organization and to only those working in CHCs or free clinics.

As more cohorts cycled through the CLI, the alumni network emerged as a key recruitment tool. After Cohort 5, the majority of recruitment was conducted through word-of-mouth and brand recognition with alumni who referred applicants from their organization and networks. While the role of engaged alumni aligned with the program's strategic goals, alumni were often most familiar with organizations already represented within the CLI, contributing to overall limitations in diversifying outreach to organizations that had not participated in earlier cohorts. We share these reflections as cautionary examples to carefully monitor gaps and biases and work early on — particularly in the design stage — to identify opportunities to overcome structural biases.

Sustain Collaboration Beyond the Program

The CLI model was grounded in intentional network building focused on systems change. The networks that many alumni relied on for professional, organizational, and advocacy support began first with the peer networking groups from their cohort. The institute facilitated a broader network beyond cohorts via electronic platforms where alumni could connect and share resources across the state. Graduation events and alumni convenings served as

In addition to self-reported measures, the BSCF assessed trends comparing alumni-led CHCs to others to assess change and impact and make data-informed decisions. For example, as the foundation monitored data like CHCs' financial status, they observed that CLI alumni often led the more stable centers.

opportunities for re-engagement and connection with other participants. Alumni were also integrated into the program as recruiters, applicant interviewers, content experts, panelists, and small-group facilitators. Given the organic nature of these networks, program staff stayed engaged with alumni's needs and adjusted their support as the network matured. Through these connections, the impact of CLI rippled out beyond individuals and organizations to support the field more broadly through a united collective of CHC advocates, including recruitment for open positions and sharing of resources (e.g., strategies for effective use of patient portals).

In the words of one alumnus, "I think CLI created a culture of sharing resources and expertise amongst community health centers in an environment that could have been overcome with competitiveness." Another shared, "I think when we're looking at new projects of some kind and have a question, our first instinct is to reach out to somebody in the CLI network to see who's experienced it and who's implemented it."

As with recruitment, alumni engagement strategies need to be periodically revisited and adapted to maintain engagement and ensure relevance for professional development. As alumni take on greater responsibilities in their organizations or the field (e.g., professional associations or statewide committees), they face increased demands on their time. We found peer support, collective action opportunities, and relevant programming motivated busy CLI professionals to continue participating in alumni activities. Their ongoing engagement enabled the field-building that lies at the heart of the cohort model and program design.

Measuring Impact Requires Sustained Investment

Ongoing evaluation was a central component of the CLI program design. Evaluation activities included an assessment of participant growth from the perspectives of both participants and their supervisors, and participants' feedback on the program. A persistent challenge for the evaluations, however, was adequately capturing and learning from organizational and field-level impacts alumni were making. At an organizational level, supervisors and other staff were a great resource for information about alumni influence. As supervisors retire or face numerous demands on their time, it is challenging to engage them directly in standard data collection approaches such as surveys and interviews. Additionally, as alumni with enhanced leadership abilities transition to new roles or organizations and no longer engage with their sponsoring supervisor, it is challenging to get a consistent picture of their trajectory.

In addition to self-reported measures, the BSCF assessed trends comparing alumni-led CHCs to others to assess change and impact and make data-informed decisions. For example, as the foundation monitored data like CHCs' financial status, they observed that CLI alumni often led the more stable centers. Alumni-led centers were also among the most common CHCs applying to the foundation's technical assistance and strategic program offerings. They also volunteered for innovative pilots and programs — additional evidence of alumni's potential for impact.

At the field level, change can take several years, is often fostered through collective rather than individual actions, and is often affected

by factors beyond the collective's control (e.g., elected officials and the economy). To understand and report on these impacts, long-term follow-up is needed along with resources to engage numerous stakeholders and account for the range of contextual and other contributing factors. Exploring impacts in these conditions may take additional investments and require taking chances on more novel or innovative evaluation methodologies building on mind mapping, social media analysis, and policy analysis.

Conclusion

Individual alumni, their organizations, and the field benefited from a long-term investment in CHC leaders that helped to bring forth a united policy advocacy voice from across the state. It was beyond the scope of the evaluations to connect with patients and community members, but the growth exhibited by organizations involved in the CLI indicate promising outcomes for those they serve. With more than a decade of direct support to leaders built on long-standing relationships for organizations, the foundation offers the CLI as a model for contributing to lasting change.

Sitting at the intersection of racial, economic, and health justice, CHCs play an active role in addressing the staggering inequities made readily apparent at the intersections of the COVID-19 pandemic and continued protests demanding racial justice. By providing access to quality, community-informed, and community-driven care, health centers intervene in the structural issues of racism and poverty in the U.S. and California health care systems. However, CHC leaders cannot bring change alone. By definition, systemic inequities are woven into the fabric of our institutions, sectors, and relationships. Broader efforts to dismantle and address these inequities require all of us to reconsider what leadership looks like.

We believe that investing in emerging leaders — particularly among groups historically or structurally discouraged from traditional and positional leadership roles, and those who have had limited access to roles of positional authority — is a key to supporting systemic change. As foundations continue to support this work, we encourage you to consider tactics that lie outside the box of traditional leadership development approaches. These include:

- centering lived experience and community connections within selection and programming;
- expanding definitions of who counts as (emerging) leaders;
- prioritizing inclusion and equity in design, support, and feedback, creating an experience for all people to be included and shape the focus;
- avoiding a "one size fits all" model to development; and
- sharing and ceding power away from philanthropy's traditional role as gatekeeper and "expert" to one that embraces and raises the contributions of partners, participants, and affected communities.

The Blue Shield of California Foundation's approach to investing in community health center leaders through the Clinic Leadership Institute reinforced such attributes as adaptability and ingenuity that are essential to fulfilling the promises of the safety net field and addressing racial and other inequities in the health care system.

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